COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

July 16, 2008

Dear Prospective Vendor:

The Department of Medical Assistance Services (DMAS) is soliciting proposals from qualified firms for a Chronic Care Management (CCM) Program Administrator. Duties of the Contractor Shall include:

- Administering a program that integrates the management of multiple chronic conditions and co-morbidities (not single condition management);
- Administering care management operations that Shall limit redundancy in medical procedures; direct participants to appropriate medical care; prevent and reduce avoidable medical costs; educate and assist participants in managing their disease(s) and condition(s); and support treatment and care from local health Providers;
- Administration of a Predictive Modeling (PM) methodology that is based on future predicted costs and not current costs. Predictive Modeling outcomes include: identifying "high risk" participants; analyzing claims data to determine the health and cost risk of potential participants; and determining the level of care management intensity for each participant;
- Managing participants' chronic condition(s) utilizing a holistic, patient-centric approach (includes medical nursing components, psycho-social issues, and behavioral health integration). The care management should focus on the participant rather than the participant's disease;
- Recruiting and enrolling individuals designated as potential participants for an Opt-in, voluntary State Plan alternative benefit program;
- Operating a call center with a toll-free line that is staffed by healthcare professionals from 7 a.m. to 7 p.m., seven days per week;
- Using evidence-based guidelines in the development of treatment plans and all other aspects of care management for the improvement of health outcomes for the participant.

This includes using nationally recognized performance measures, such as HEDIS, on important dimensions of care and service;

- Developing either partnerships or working relationships with healthcare Providers and medical and advocacy groups for the collaboration of improving the quality of care of the participant. This includes collaborating with community service programs to provide information and resource directories to the participants; and
- Committing to a cost neutral target that is based on claims analysis.

Specific details about this procurement are in the enclosed Request for Proposal (RFP) 2008-01. Contractors must check the DMAS web site at www.dmas.virginia.gov or check the eVA web site at http://www.eva.virginia.gov for any addendums or notices regarding this RFP.

The Commonwealth will not pay any costs that any Contractor incurs in preparing a proposal and reserves the right to reject any and all proposals received.

All issues and questions related to this RFP should be submitted in writing to the attention of Jeff Beard, Provider Integrity Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219. Offerors are requested not to call this office. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to ccm@dmas.virginia.gov.

Sincerely,

Christopher M. Banaszak
DMAS Contract Manager

Enclosure

REQUEST FOR PROPOSALS
RFP 2008-01

Issue Date: July 16, 2008

Title: Virginia Medicaid/FAMIS Chronic Care Management Administrator

Period of Contract: An initial period of three years from award of contract, with provisions for three one year renewals.

All inquiries should be directed in writing via email in MS Word Format to: ccm@dmas.virginia.gov or

Jeff Beard
Program Monitor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Deadline for submitting inquiries is **2:00 pm E.S.T., Tuesday, August 5, 2008**

Proposal Due Date: Proposals will be accepted until **2:00 p.m. E.S.T. on Wednesday, August 27, 2008**

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

"RFP 2008-01 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: Chris Banaszak

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

A mandatory pre-proposal conference will be held at 10:00am on Tuesday, August 5, 2008 at the Department of Medical Assistance Services 7th Floor Conference Room, 600 E. Broad Street, Richmond, VA 23219. The purpose of this conference is to allow potential bidders/offerors an opportunity to present questions and obtain clarification relative to any facet of this solicitation. Due to the importance of all offerors having a clear understanding of the scope of work and requirements of this solicitation, attendance at this conference Shall be a prerequisite for submitting a proposal. Proposals will only be accepted from those offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. Due to space limitations, Offerors Shall be

limited to two representatives each. Bring a copy of the solicitation with you. Any changes resulting from this conference will be issued in a written addendum to the solicitation.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone	Date Signed
Fax Number	
eVA Registration Required	eVA Vendor #:
Check Applicable Status Corporation ---------- Partnership --------- Proprietorship -------- Individual ------Woman Owned ---------- Minority Owned ---------- Small Business ---------	

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

VIRGINIA MEDICAID/FAMIS

CHRONIC CARE MANAGEMENT ADMINISTRATOR

RFP 2008-01

July 16, 2008

TABLE OF CONTENTS

RFP 2008-01 Virginia Chronic Care Management Program Administrator

SECTION 1 INTRODUCTION

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the *Social Security Act*, and Virginia's State Children's Health Insurance Program, referred to as the Family Access to Medical Insurance Security (FAMIS), under Title XXI of the *Social Security Act* for people with low-income. These programs are financed by federal and state funds and administered by the state according to federal guidelines. Both programs include coverage of medical services for eligible Medicaid and FAMIS fee-for-service enrollees.

The Department provides Medicaid to individuals through three programs: MEDALLION, a Primary Care Case Management (PCCM) program utilizing contracted Primary Care Providers; Managed Care, a program utilizing contracted managed care organizations (MCO); and Fee-for-Service (FFS), the standard Medicaid program. Individuals who receive home and community-based waiver (HCBW) services are in the FFS program. Additional information on HCBW services can be found in Attachment IX. Although FAMIS is not a Medicaid program, it is provided through the FFS, PCCM, and MCO delivery systems.

The Department's managed care programs primarily serve four groups: FAMIS Plus (Medicaid children), FAMIS, pregnant women, and individuals who receive Supplemental Security Insurance. Approximately 2,000 Primary Care Providers are enrolled in MEDALLION, and seven MCOs participate in managed care and FAMIS. Approximately 103 Virginia localities have MCOs. Additional information on FAMIS, managed care programs, including a detailed description of areas covered by managed care programs and MCO characteristics can be found in Attachment VI.

The Department will be moving Medicaid eligibles who have dual enrollment (Medicare and Medicaid) and are adult Recipients in the Elderly and Disabled with Consumer-Directed (EDCD) Waiver who live in the Tidewater area into a Managed Care Organization (MCO) in February 2009. Adult EDCD Recipients in the Richmond, Virginia area will be moved into a MCO in December 2009.

Enrollment for each category, based on the Statistical Record for Fiscal Year 2006, is as follows:

Fee For Service	220,001	(Approximately 20,195 received HCBW services)
MEDALLION	62,771	
Managed Care	369,518	

The Department is soliciting proposals for a Chronic Care Management Program Administrator through a competitive procurement process. The chronic care management program Shall include specified Medicaid and FAMIS Fee-For-Service (FFS) enrollees. This Request for Proposal (RFP) is for the provision of Chronic Care Management services statewide for Medicaid and FAMIS enrollees.

Based on the proposals, the Department is planning to select and enter into a contractual agreement with one or more qualified Contractor(s) for the provision of chronic care management (CCM) services in the Commonwealth. The general scope of responsibilities of the Contractor, which are more fully described later in the RFP, include using Predictive Modeling to identify participants, providing outreach and education on CCM programs and chronic illnesses, performing an initial assessment on enrollees, counseling and monitoring participants' adherence to treatment plans, providing telephonic and face-to-face care management, and maintain a toll-free call line for all program participants. The Contractor Shall also monitor clinical health outcome measures and track changes in health care expenditures for participants in the CCM program.

It is the Department's intention to enter into a contract for a care management program that (1) helps participants learn skills and get connected to services that reduce their catastrophic or severe illness, and (2) takes a holistic approach to enrollees, taking into account cultural, educational, social, and economic issues that affect enrollees' ability to manage chronic diseases.

The Contractor(s) selected in response to this RFP must be able to perform the services described in the RFP beginning Monday, January 5, 2008 The Contractor Shall comply with all applicable administrative rules and the Department's written policies and procedures, as may be amended periodically. Copies of such rules and policies are available from the Department.

TABLE A lists the key program features and a brief description of the RFP requirements of the Contractor.

TABLE A – Key Requirements

Number	Key Program Features	Program Requirements
1.	Corporate Experience	• Minimum three years of chronic care management or disease management experience, with at least one year with Medicaid populations in Virginia or other States • Management of high risk members
2.	Accreditation	Must have current URAC and/or NCQA accreditation for disease management and/or Case Management and maintain a "good standing" with the organization
3.	Chronic Care Model	• Program design must integrate the management of multiple disease states and co-morbidities (not single condition management) • Must incorporate a holistic, patient-centric model (includes medical nursing components, psycho-social issues, and behavioral health integration)
4.	Care Management	• Care management that addresses enrollees in level of risk and healthcare intensity

Number	Key Program Features	Program Requirements
		• Combination of face-to-face, mail, and telephonic care management
5.	Participant Assessments	Holistic assessment that includes medical nursing, psychosocial, and behavioral health issues.
6.	Medication Therapy Management	Care Managers must be able to demonstrate clinical expertise in addressing medication issues and provide a documented workflow
7.	Provider Interface	Contractor's organization must demonstrate leadership, innovation, and examples of partnership/working relationships with the medical community and advocacy groups
8.	Call Center	Operate at a call center staffed by healthcare professionals from 7 a.m. to 7 p.m. seven days per week
9.	Risk Stratification	Utilize a validated Predictive Modeling methodology that is appropriate for Medicaid populations; based on future predicted costs vs. current costs
10.	Data Interface	Have the ability to accept data in multiple formats and feeds from the Department
11.	Coordination of Care	Care Management Operations Shall exhibit the ability to: • Limit redundancy in medical procedures • Direct individuals to appropriate medical care • Manage transition between various settings (e.g., institutional to community-based healthcare; hospital to home-base services)
12.	Behavioral Health Integration	Have a proven track record concerning the coordination of treatment plans, interventions, and medications for members with behavioral health needs
13.	Patient Resources	Collaborate with community services and programs and have resource directories and workflows in place for program participants
14.	Participant and Provider Satisfaction	Measure participant satisfaction
15.	Participant Enrollment	Recruit and enroll individuals designated as potential participant members
16.	Financial Methodology	• Contractor must commit to a cost neutral target that is based on claims analysis • Methodology Shall be certified by independent review

1.1 Definitions

The following terms when used in this RFP Shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

1. Administrative Cost - Costs to the Contractor related to the administration of this RFP. Costs of Sub-Contractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP (including, but not limited to, postage, personnel, rent) are considered to be an "administrative cost."

2. Administrative Services Fee - The per member per month amount the Contractor Shall be paid by the Department for provision of the services outlined in this RFP.

3. Annually – For the purposes of contract reporting requirements, annually Shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.

4. Assessment - The gathering of specific information about the participant's condition and evaluation of the participant's knowledge and understanding of his condition in order to determine the specific educational needs of the participant and to recommend an appropriate intervention plan.

5. Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.

6. Call Center – A coordinated operation that accepts incoming telephone calls from participants, Providers, and other parties to answer questions and give CCM support and information.

7. Care Management – The practice of managing or supervising the management of the participant's care. Coordination of care includes an initial and on-going clinical Assessment; development and evaluation of participant goals in the CCM program; condition-specific education; routine monitoring of the participants condition; telephonic and/or face-to-face interaction with participants; and physician interaction and Referrals for additional ancillary services, as needed.

8. Care Manager – The individual facilitating care management. This can be conducted face-to-face, telephonically, and via other means.

9. Care Management Team – a group of health care professionals employed by the Contractor to assist the individual's care manager. This team works together to address the physical, mental, & psycho-social needs of the client. Every Care Manager is a part of a Care Management team. The team must include a RN and a mental health professional and be under the supervision of the Contractor's Medical Director.

10. Chronic Care Management (CCM) – The Department's program and purpose of this RFP, which Shall be administered through the Chronic Care Management Program Administrator/Contractor.

11. Chronic Care Management Information Platform System (CCMIPS): The information system that includes a database and web-based information system that integrates member registries, care management, member education, and Provider communication portions of the CCM.

12. Chronic Care Management Program Administrator (CCMPA) - The entity that contracts with the Department of Medical Assistance Services to manage or direct a Chronic Care Management (CCM) program on behalf of the Department. For the purposes of this RFP, and resulting contract, the CCMPA refers to the administration of Care Management of the Department's CCM program statewide (or in specific geographic locations, depending on the contract) for Title XIX Medicaid and Title XXI FAMIS or FAMIS Plus fee-for-service Recipients to include coordination and management of such CCM services. The CCMPA will be referred to in this RFP as the "Contractor."

13. Clinician - Any individual who is licensed to treat patients, and can be internal or external to the Contractor; however, a Clinician external to the Contractor must be able to discuss issues related to programs offered by the Contractor.

14. CMS - Centers for Medicare & Medicaid Services. This is the federal agency that oversees the administration of Medicare and State Medicaid services.

15. Co morbid Condition – A condition that is secondary to, and often related to, the primary condition.

16. Contract - The signed and executed document resulting from this RFP between the Department and the Contractor / CCMPA.

17. Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

18. Contractor - The corporation or company that the Department/DMAS has contracted with for Chronic Care Management and administration.

19. Covered Service – Chronic Care Management services for Medicaid or FAMIS fee-for-service enrollees as described in Sections 4 of this RFP. This does not include the provision of medical services.

20. Department - The Virginia Department of Medical Assistance Services.

21. Disease Management (DM) – A program designed to slow the progression of chronic disease and to help contain health care expenditures for program participants. The program targets specific chronic conditions (condition-driven) with healthcare measurements and guidelines. Virginia's DM program focuses on five chronic conditions. More information on Virginia's DM is located in ATTACHMENT VIII.

22. Disenrollment - The discontinuation of an enrollee's eligibility to receive covered services under the terms of this RFP.

23. Eligible – An individual who is a non-excluded Medicaid or FAMIS fee-for-service enrollee and is identified by the Contractor as a candidate for enrollment into the CCM program.

24. Encryption – A security measure involving the conversion of data into a format that cannot be interpreted by outside parties.

25. Enrollee – See Participant

26. Enrollment - The process by which the Contractor notifies a Medicaid or FAMIS enrollee of eligibility for the CCM program and receives permission from the Medicaid or FAMIS enrollee to enroll.

27. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to the Contract referred to in this RFP; or (b) maintained by a Sub-Contractor to provide services on behalf of the Contractor.

28. FAMIS Enrollee - A person enrolled in the Department's State Children's Health Insurance Program (FAMIS or FAMIS Plus program) who is identified by the Department as being eligible for CCM services due to enrollment in fee-for-service FAMIS or FAMIS Plus. The Contractor(s) Shall be responsible for determining whether the CCM-eligible persons meet the criteria that would allow their Enrollment into the CCM program.

29. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment amounts for defined services.

30. Fiscal Year (State) – July 1 through June 30.

31. Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in payment of an unauthorized benefit.

32. Grievance – An expression of dissatisfaction by the Enrollee about any action taken by the Contractor or service Provider.

33. Health Care Expenditures – For the purposes of this RFP and the Contract, health care expenditures include inpatient hospital, outpatient hospital, physician, pharmacy, and lab and x-ray expenditures for Medicaid and FAMIS Enrollees.

34. Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care Providers, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

35. High Intensity – See Tier-1.

36. Home and Community-Based Waiver Services - The range of community support services approved by the Centers for Medicare & Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to individuals who would otherwise require the level of care provided in an institutional setting. Virginia currently offers eight waiver programs.

37. Initial Comprehensive Assessment – also known as a Comprehensive Assessment. It is an Assessment conducted with the CCM Enrollee, primary caregiver, or guardian. This Assessment is completed by using a Comprehensive Assessment

Tool (CAT) designed specifically for this population. This Assessment is completed immediately after Enrollment into CCM and is designed to obtain information which the Contractor is unable to gather and extract from claims data and other resources. This Assessment is used in the development of a complete holistic Assessment and treatment plan for the Enrollee.

38. Inquiry – An oral or written communication by or on the behalf of an Enrollee to the Contractor that may be: 1) questions regarding the need for additional information about benefits, plan requirements or materials received, etc.; 2) provision of information regarding a change in the Enrollee's status such as address, family composition, etc.; or 3) a request for assistance such as obtaining translation services, etc. An Inquiry is not an expression of dissatisfaction.

39. Low Intensity – See Tier-2.

40. Managed Care Organization - An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Managed Care Organizations and FAMIS programs.

41. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible persons to utilize the services included in the CCM program and to be aware of the services offered by the Contractor pursuant to this RFP and Contract.

42. MEDALLION – Virginia's Medicaid Primary Care Case Management (PCCM) program that utilizes contracted Primary Care Providers.

43. Medicaid Enrollee- Any person identified by the Department as being eligible for Medicaid services due to enrollment in fee-for-service Medicaid or FAMIS. The Contractor(s) Shall be responsible for determining an individual's eligibility into the CCM program. Exceptions are listed in Section 3.1 of this RFP.

44. Member - See participant.

45. Monthly – The 15th day of each month for the prior month's reporting period. For example, January's Monthly reports are due by February 15th; February's are due by March 15th, etc.

46. Must - See shall

47. Net Savings – The percent difference between the expected per member per month health care expenditures for services in the program year (calculated using the Predictive Modeling methodology approved by the Department) and the actual per member per month health care expenditures, less program costs observed in the program year.

48. Neutral Cost – The administrative cost to operate and fulfill this RFP must be captured in savings in order to reimburse all program expenditures.

49. Offeror – Refers to a company that is submitting a response to this RFP.

50. Participant - A Medicaid or FAMIS Fee-for-Service Enrollee who has been identified as CCM Eligible and who is actively receiving Care Management services in the CCM program.

51. Patient Incentive Plan (PIP) - A program that rewards CCM Participants for adherence to treatment plans, preventive measures, and health related behavior improvements.

52. Predictive Model – The methodology developed by the Contractor and approved by the Department for developing the expected per member per month health care expenditures for the program year to be used in the calculation of net savings and predicting the health risk of individuals.

53. Primary Care Physician (PCP) - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating Referrals for specialist care; and for maintaining the continuity of patient care. A Primary Care Physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

54. Primary Care Provider - A Primary Care Physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating Referrals for specialist care; and for maintaining the continuity of patient care.

55. Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

56. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts payment, in full, for providing benefits and accepts the amounts paid pursuant to a Provider agreement with the Department.

57. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of Chronic Care Management practices.

58. Quarterly – A time period defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.

59. Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.

60. Recipient – See Medicaid Enrollee, FAMIS Enrollee.

61. Recipient Monitoring Unit (RMU) – A unit within the Department that conducts ongoing reviews of a Participant's need for medical services for Fee-for-Service type of Medicaid and FAMIS. The review Shall determine if a Participant Shall be placed in the Client Medical Management program and restricted to one physician and/or pharmacy. Recipients in the Client Medical Management program receive oversight from the Department. More information is located in Attachment VII of this RFP.

62. Referral – A request for a Participant to be evaluated and/or treated by a different physician, usually a specialist, or other healthcare service Provider.

63. Semi-annually – A time period defined as within 30 calendar days after the end of a six-month period, unless otherwise specified by the Department.

64. Services - See covered service.

65. Shall - Indicates a mandatory requirement or a condition to be met.

66. State - Commonwealth of Virginia.

67. State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted by the Department to CMS for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it Shall be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal Financial Participation. The Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-325, as amended.

68. Sub-Contract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department (e.g., claims processing, Marketing), when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by Contract with the Department.

69. Sub-Contractor - Any State approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department.

70. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.

71. Tier-1 – High Intensity level Participants in the CCM program. This is determined by the Contractor's Predictive Modeling tool.

72. Tier-2 – Low Intensity level Participants in the CCM program. This is determined by the Contractor's Predictive Modeling tool.

1.2 Purpose of the RFP

It is the intent of the Department to Contract with a health care organization to be a Chronic Care Management Program Administrator to implement an Opt-in CCM program. The purpose of the CCM program is two-fold. The first purpose addresses the need for enhanced Care Management to improve quality of care and health outcomes for CCM Participants. This Shall be accomplished by:

- Identifying "high risk" Participants using Predictive Modeling;
- Incorporating enhanced Care Management and services monitoring;
- Tailoring a holistic treatment plan to each Participant - treating the person rather than a condition;

- Supporting treatment and care through local healthcare Providers through educating and assisting Participants in managing their conditions;
- Improving health outcomes for Participants using evidence-based guidelines;
- Intervening with Participants to prevent and reduce avoidable medical costs through improving self-management skills;
- Reducing Participant's utilization of unnecessary services; and
- Coordinating medical services on a local level by a professional healthcare staff.

The second purpose of the program is to reduce health care costs, thereby resulting in cost savings to the State. This Shall be a direct outcome of risk prevention and personalized care management, thus avoiding unnecessary acute care services, emergency room visits, and clinical and physician visits, which tend to be more expensive and more readily accessed.

The two fold purpose of the CCM program goes beyond health status improvements and illness management; it directly intervenes with those Participants who are at the most risk of high service utilization. On the front-end, CCM Shall prevent the unnecessary use of services using proven evidence-based guidelines in the development of the treatment plan. On the back end, this approach Shall reduce and prevent the potential for risks of catastrophic or severe illness, while providing only those services that are essential for treatment. It focuses on a proactive approach as opposed to a reactive approach of care and service management.

SECTION 2 BACKGROUND

The 2005 Virginia General Assembly amended the 2004-2006 Appropriations Act (see Attachment II) to authorize the Department of Medical Assistance Services to outsource the administration of a program to provide disease state and Chronic Care Management services for Medicaid Recipients to an administrative services Contractor. In addition, the Act provides that the Department Shall have the authority to amend the State Plan as necessary for Title XIX (Medical Assistance) of the Social Security Act within 280 days or less from the enactment of the Act to provide Chronic Care Management services to individuals enrolled in these programs.

In January 2006, the Department implemented the *Healthy Returns*^{SM} Disease Management (DM) program. The DM program targets Fee-for-Service Medicaid and FAMIS Enrollees who have asthma (children and adults), congestive heart failure (children and adults), coronary artery disease (adults), and diabetes (children and adults), and in May 2006 added chronic obstructive pulmonary disease (adults). Health Management Corporation (HMC) is the Contractor for Virginia's DM program. The DM program focuses on preventative care, improving a Participant's quality of care, the promotion of self-management, and the appropriate use of medical services. The DM program consists of telephonic and mail interventions.

It is the intent of the Department to implement a comprehensive Chronic Care Management (CCM) program that Shall target Medicaid and FAMIS fee-for-service (FFS) Participants. Participants identified as "high risk" though a Predictive Modeling system, and due to high utilization costs, are in need of specialized care management.

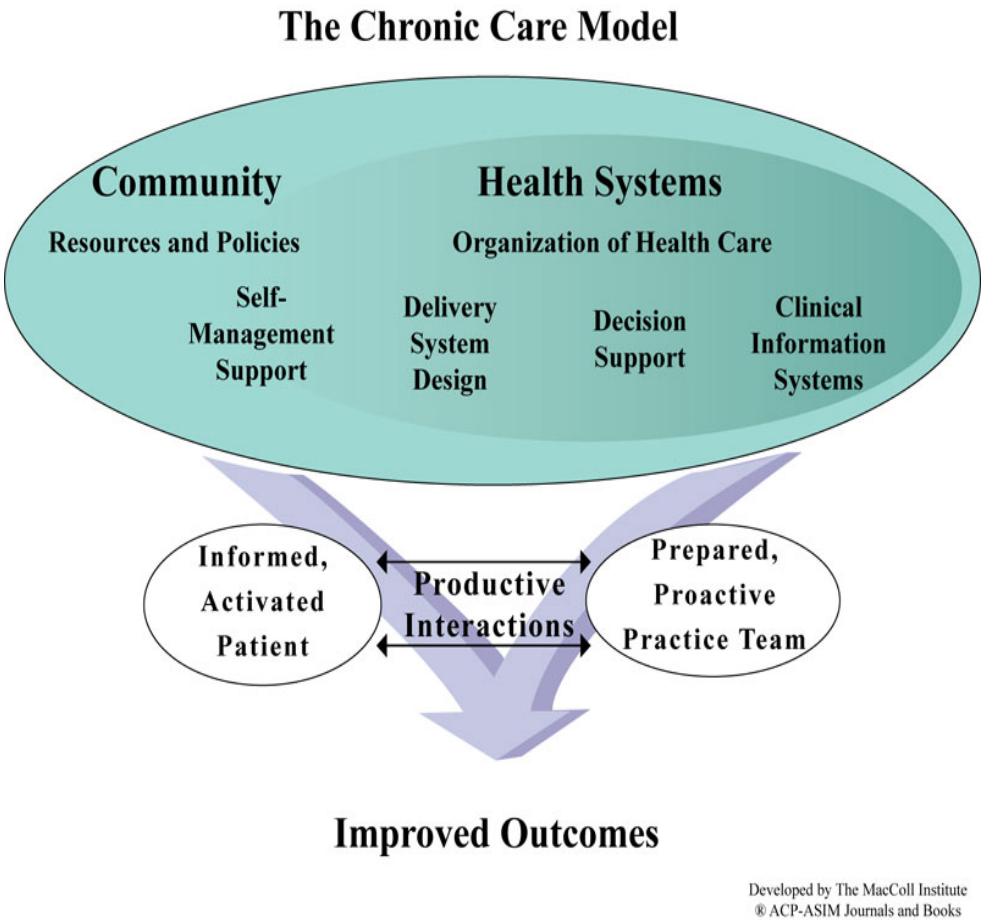
Medicaid FFS Recipients who qualify as potential Enrollees for the DM program are excluded from the CCM program. If an individual is enrolled in the CCM program and later qualifies for the DM program, the individual must be discharged from the CCM program. A recommendation of a transfer to the DM Contractor Shall be required. The Department will collaborate with the Contractor on the transfer of the individual to the DM program.

Based on paid claims from fiscal year 2007, the number of potential Eligibles is approximately 78,700. TABLE B below shows the top ten (10) most expensive diagnosis claims that were paid in fiscal year 2007. It also shows the number of CCM potential Eligibles with each diagnosis. The Department will make available three months of claims data of potential Eligibles to those Offerors who attend the pre-proposal conference. Offerors Shall be required to sign a confidentiality release upon receiving the data.

TABLE B – Top Ten Highest Cost Diagnosis by Claims

Diagnosis	Total Amt. of Claims Paid in FY2007	# of Claims	# of Eligibles with Dx
Episodic mood disord NOS	$6,445,947.48	13,896	194
Bipolar disorder NOS	$6,266,756.04	10,443	181
Depressive disorder NEC	$5,392,698.25	10,682	235
Posttraumatic stress dis	$3,429,630.98	6,058	133
Single LB-hospital by CD	$3,086,165.47	60	43
Mod mental retardation	$2,964,572.07	2,761	73
Oppositional defiant dis	$2,867,500.45	5,616	156
ADD child w hyperact	$2,639,383.35	6,955	210
Ac respiratory failure	$1,906,923.18	1,198	77
Mental retardation NOS	$1,878,413.81	1,723	67

The CCM program Shall take a holistic approach to Participant care, taking into account cultural, educational, social, and economic issues that affect the Participants' ability to manage chronic diseases. The CCM program Shall connect Participants to services and help Participants learn skills and connect to services that will reduce the chance of catastrophic or severe illness. A holistic, patient-centric model must include psycho-social issues and behavioral health integration. Medicaid services will be limited by State Plan Alternative Benefits package. The program will follow the Chronic Care Model as shown below for improved outcomes.



SECTION 3 NATURE AND SCOPE OF SERVICES

3.1 Target Population

The CCM program Shall serve a designated percentage of Medicaid and FAMIS fee-for-service Participants who have been identified through the Contractor's Predictive Modeling system to be at "high risk" for greater medical costs and/or have the highest cost of service utilization. These are individuals who are at risk of demonstrating poor health outcomes; experiencing fragmented health care delivery; have high cost utilization of services; or whose pattern of health services access may indicate an inappropriate utilization of health care resources.

The CCM program may include individuals who are enrolled in Virginia's Medallion program. However, those enrolled in the managed care program are excluded.

The program Shall include all Medicaid and FAMIS fee-for-service Enrollees with the exception of individuals who:

- Are determined to be qualified for enrollment in Virginia's *Healthy Returns*SM Disease Management program;
- Are enrolled in Medicaid Managed Care Organizations;
- Are enrolled in Medicare (dual eligibles);
- Are living in institutional settings (such as nursing homes);
- Are enrolled in PACE (Program of All Inclusive Care for the Elderly);
- Are living in an intermediate care facility for individuals with mental retardation (ICF/MR);
- Are enrolled in hospice; or
- Have third party insurance.

3.2 Duration of Contract

The duration of the initial Contract resulting from this RFP is three years and will commence after successful implementation (as determined by the Agency), with up to three one-year renewals. This Contract may be renewed by the Commonwealth upon written agreement of both parties for up to three successive one-year periods, under the terms of the current Contract, and at a reasonable time (approximately 90 days) prior to the Contract date. The Contract date will begin on the implementation date of the CCM program.

The Department Shall award contracts based on the criteria and process described in Sections Three (3) and Four (4) of the RFP.

3.3 Mandatory Program Specifications

The following areas have been determined as mandatory requirements for the program. The successful Offeror must be able to meet each of the following requirements. Offerors Shall indicate their understanding and ability to perform these tasks in their response to the Technical Proposal to the Department:

a. Demonstrate via the Offeror's references and statement of work a minimum of three (3) years of Chronic Care Management or Disease Management experience with target populations of comparable size (defined as the number of anticipated Participants) or patient mix. At least one (1) of the required three (3) years must be Medicaid health care specific experience. The Offeror must describe the size, scope, and length of experience with a Medicaid population; and

b. The Offeror's Disease Management and/or Case Management Program must be accredited by the Utilization Review Accreditation Commission (URAC), and/or the National Committee Quality and Accreditation (NCQA). Copies of the Offeror's accreditation must be submitted with the Technical Proposal. The

Contractor Shall maintain accreditation and Shall provide documentation each year with the Annual Report, or more frequently, upon request by the Department.

3.4 Contract Administration and Management

The Department Shall designate a Program Monitor to coordinate activities, resolve questions, document and monitor the selected Contractor's performance, and be the Contractor's primary liaison in working with other Department staff. The Program Monitor Shall initially receive and review all progress reports and deliverables, oversee scheduling of meetings with State staff, and maintain first-line administrative responsibility for the Contractor. The Program Monitor Shall monitor, document and evaluate the work performance of the Contractor, accept deliverables, and authorize the payment for services rendered.

The successful Contractor Shall designate a Project Director (PD) who Shall have day-to-day responsibility for supervising the performance and obligations under Contract. The selected PD Shall work closely with and Shall receive policy direction from the Department's Program Monitor. The Contractor Shall not change the designation of its PD without the Department's prior written approval, which approval Shall not be unreasonably delayed or withheld more than thirty days from receiving notice from the Contractor.

Except where required by this Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor Shall not provide CCM services prior to the effective date that the Medicaid or FAMIS Enrollee chooses to participate in the CCM program with the Contractor. Additionally, the Contractor Shall not provide CCM services beyond the month that it is notified by the Department that the Recipient is no longer eligible for Medicaid or FAMIS Fee-for-Service, or if the Participant requests to disenroll from the CCM program.

A contract is subject to changes in federal and State changes to funding, population, and services. This includes expansions of managed care by the Department. If the Managed Care Organization (MCO) programs are expanded or contracted, the Department will notify the Contractor of any expansion or contraction of the managed care program and its projected impact on payment at least 90 days prior to the effective date of the managed care expansion.

In the event of federal or State regulatory or program changes, or federally approved Medicaid waivers for Virginia that result in an increase in population, the Contractor Shall provide services specified under this RFP to the impacted population and the Department reserves the right to negotiate payment to the Contractor. The Department also reserves the right to negotiate payment to the Contractor as a result of any increase or decrease in population due to federal or State regulatory changes, or federally approved Medicaid waivers for Virginia. The Department will notify the Contractor of any additions or deletions of programs and/or populations and its projected impact on payment at least 90 days prior to the effective date of the addition or deletion of programs and/or populations.

SECTION 4 TECHNICAL PROPOSAL REQUIREMENTS

This section contains the technical proposal requirements for this RFP. The Offeror Shall provide a detailed narrative of how it Shall define and perform each of the required tasks listed in this section and by cross-referencing the Offeror's proposal response to each RFP requirement. The narrative Shall demonstrate that the Offeror has considered all the requirements and has developed a specific approach to meeting them in order to implement a successful project. It is not sufficient to state that the requirements Shall be met. The description Shall correspond to the order of the tasks described herein.

The Offeror may perform all of these processes internally or involve Sub-Contractors for any portion. Sub-Contractors Shall be identified by name and by a description of the services/functions they Shall be performing. The Contractor Shall be wholly responsible for the performance of this entire Contract whether or not Sub-Contractors are used.

4.1 Identification and Enrollment of Target Populations

The Contractor Shall be responsible for enrolling Eligible Members into the CCM program and verifying their eligibility for the CCM program. The Department will provide the Contractor with data from the Virginia Medicaid Management Information System (VAMMIS), which is operated by the Department's fiscal agent, First Health Services Corporation (FHSC), on a Quarterly basis. More information on this procedure will be found later in this RFP. The Contractor Shall upload the data from the Department and analyze accordingly. The Contractor Shall use their own Predictive Modeling tool and methodology, as approved by the Department, to identify individuals who are at risk for greater medical costs. The Department must review and approve the identified individuals who will be recruited for the CCM program by the Contractor.

Participant selection and Enrollment are for those individuals:

a. Who fall in the designated percentile of Participants as indicated in the Contract;
b. Who have been determined to meet the criteria and description of the program's target population;
c. Who have a medical condition, or combination of conditions, and behavior that warrant CCM as described in this RFP; and
d. Who have medical costs and utilization of medical services that can be reduced from enhanced CCM and behavioral health modifications. Individuals who are determined by the Contractor's predictive methodology to not be impacted by the CCM program Shall be excluded from Enrollment. The Contractor Shall submit a Quarterly report of individuals who were determined to be excluded due to this reason.

Based on paid claims from fiscal year 2007, the number of potential Eligibles is approximately 78,700. TABLE C below gives a break down of potential Eligibles by Region. The Regions used in TABLE C are identified and defined in Attachment III.

TABLE C – Potential Eligibles for CCM by Region of the State

Region	# of Potential Eligibles
Southwest	41,600
Northern Virginia	15,600
Tidewater	12,600
Central Virginia	5,300
Southside	3,600

4.1.1 Enrollment

The Contractor's predictive methodology Shall place each Participant in either the first or second tier of care management. The Offeror Shall include with its response to the RFP an outline and description of the Enrollment process, criteria, and risk scoring methodology by which its predictive methodology and other procedures, such as the initial comprehensive Assessment, are used to determine High Intensity or Low Intensity Care Management for each Participant. The Department must approve the methodology and risk scoring for intensity determination.

Recruitment: Since this is an Opt-in program, the Offeror Shall also describe the methods that it Shall use to recruit Enrollees. The description Shall include a timeline, methods of obtaining contact information of the potential Enrollees, and methods of contacting and enrolling individuals into the program. At a minimum, recruitment methodology must include five attempts to contact the potential Enrollee. This methodology Shall include at a minimum a mix of telephonic contacts and mailings. Telephonic contacts must include after hours calls, evenings, and weekends if necessary.

- Initial Enrollment: Once the number of Participants for the CCM program is determined by the Predictive Modeling system, the Contractor Shall begin the recruitment process within ten days. During the implementation process the Contractor Shall submit weekly status reports to the Department. Status Report requirements are located in Section 4:19.1 of this RFP. The Contractor Shall host weekly telephone conferences to discuss the weekly status reports. The agenda, format, and call arrangements must be approved by the Department.

The Contractor Shall process claims data in the Predictive Modeling tool on a Quarterly basis for the purpose of determining who is Eligible for the CCM program. The Contractor Shall receive updated Medicaid and FAMIS eligibility data from the Department on a Monthly basis.

For an individual to be recognized by the Department as enrolled in the CCM program, the following requirements must be met:

- A face-to-face or phone conversation with the Participant, primary caregiver, or legal guardian of a minor, discussing the CCM program; and

- A signed consent form mailed or delivered to and returned by the Participant, primary caregiver, or legal guardian acknowledging Enrollment into CCM.

The Contractor Shall only receive per member per month (PMPM) payment for Participants that meet the Enrollment requirements and are recognized as enrolled Participants by the Department.

4.1.2 Projected Participation and Utilization Goals Report

The Offeror Shall include with its RFP proposal projections, at a minimum, a projected percent of CCM-Eligibles the Offeror expects to enroll in the program each year.

In addition, the Offeror Shall include with its response to the RFP proposal a detailed implementation strategy and work plan that it Shall utilize to achieve the projected participation utilization. The Offeror's proposed strategy Shall sufficiently describe the basis for the Offeror's PMPM cost proposal. See Section 4.19.1 for additional requirements for the weekly implementation work plan status report.

4.1.3 Levels of Member Participation

The Contractor Shall stratify CCM Participants into two categories: Tier-1 – High Intensity; and Tier-2 – Low Intensity. Descriptions of the two tiers is below.

Tier-1, also known as "High Intensity", includes Participants who:

1. Have the highest predicted cost and at highest medical risk;
2. Require face-to-face initial comprehensive health care Assessment;
3. Receive telephonic contact from the Care Manager at a minimum of once per month; and
4. Receive communication from the Care Management Team via mail and other methods on a Monthly basis.

Tier-2, also known as "Low Intensity", includes Participants who:

1. Are at a lower predicted cost and health risk than Tier-1 Participants;
2. Do not require face-to-face Care Management except for unusual circumstances, which are determined by the Care Manager or care team. A face-to-face Assessment and/or visit Shall be conducted in the following situations:
    - The individual/Participant or caregiver is unable to complete the Assessment tool by phone with the care manager; and/or
    - The clinical discretion of the care manager.

3. Receive personalized telephonic Care Management contact at a minimum once per month, as well as mailings and other methods of communication on a Monthly and Quarterly basis.

4.1.4 Disease Management Participants

An individual who is qualified for the Virginia Healthy Returns[SM] Disease Management (DM) program is excluded from the CCM program. The Contractor Shall not receive data on DM eligibles.

If an individual participating in the CCM program is later determined to be qualified for the Disease Management program, [diagnosed with asthma (children and adults), congestive heart failure (children and adults), coronary artery disease (adults), diabetes (children and adults) or chronic obstructive pulmonary disease (adults)], the individual must be discharged from the CCM program. Information on Virginia's DM program can be found in Attachment VIII.

4.2 Health Care Assessments

The goal of Virginia's CCM program is to manage the Participant, as opposed to managing a disease. Therefore, a complete Assessment process Shall include an initial comprehensive health care Assessment and a complete holistic Assessment. The complete Assessment must include, but not be limited to, clinical and behavioral aspects, and support systems available for the Enrollee. Assessments should include a focus on stabilizing and managing any existing behavioral health conditions (diagnosed or undiagnosed). The CCM should help the Participant identify and address behavioral health disorders (such as depression or anxiety) and psycho-social barriers that prevent treatment adherence and positive lifestyle changes.

An Initial Comprehensive Assessment is conducted with the CCM Enrollee, primary caregiver, or guardian. This Assessment is completed by using an Initial Comprehensive Assessment Tool (CAT) that the Contractor creates for this specific population, and approved by the Department. This Assessment is completed immediately after Enrollment into CCM and is designed to obtain information which the Contractor is unable to gather and extract from claims data and other resources. The CAT is used in the development of a complete holistic Assessment and treatment plan for the Enrollee.

The Offeror Shall describe in its response to the RFP:

- How Participants will be initially assessed on the requirements within this RFP;
- How an Initial Comprehensive Assessment will help the Offeror determine the intensity level of Care Management for an Enrollee;
- A description of the comprehensive Assessment tool (CAT) that will be used, and submit a draft copy of the tool with its RFP response;

- Other Assessment tools and procedures used; and
- The frequency of Participant Assessments that will be conducted by the Contractor, and what determines the need for an updated Assessment.

All Assessment tools and procedures must be approved by the Department prior to being used by the Contractor. Assessment tools created, developed, and used in the performance of this Contract for the CCM program Shall be sole property of the Department. See Section 11.19 for additional information.

The Contractor should consider using particular health risk Assessment instruments, quality of life instruments, or other Assessment tools such as the patient Activation Measure (PAM), Short Form-8 (SF-8), or the Patient Health Questionnaire (PHQ).

4.3 Treatment Plans (TP)

Treatment plans (TP) Shall have a holistic approach. Assessment updates are expected to adjust/update TPs. The Offeror Shall provide with its response to the RFP a description on how its program addresses co-morbid conditions in Assessments, treatment plans, and on-going care management. The response Shall demonstrate the Offeror's knowledge and ability to integrate nursing components, psycho-social issues, and behavioral health in a holistic, patient-centric Chronic Care Management model. Medicaid services will be limited by State Plan Alternative Benefits package.

Assessments and Treatment Plans Shall be conducted by licensed medical professionals in accordance with URAC and/or NCQA accreditation Core Standards and Disease Management Standards, and who are trained and experienced with a Medicaid population.

Treatment plans Shall be designed to help the Participant:

a. Better manage Participant's health;
b. Better understand the appropriate use of resources needed to care for Participant's health;
c. Better identify "triggers" or negative changes affecting Participant's health condition(s) with the goal of seeking appropriate care before a crisis is reached;
d. More appropriately utilize the health care system including making and keeping scheduled appointments with Providers; and
e. Better understand and follow his treatment plan.

The Contractor Shall adopt standards to improve the health of Participants by providing CCM services based on an individualized TP that utilizes evidence-based practice guidelines and includes promoting collaborative relationships with

Providers, providing Participant and Provider education, and employing reporting and feedback loops for decision-making with Providers and Participants.

A TP is to be based on the Participant's Assessment. The Contractor Shall assure and coordinate the development of the TP to be completed and in place within sixty (60) days of the Participant's Enrollment.

The TP must also include specific provisions for periodic (not less than Semi-annual) review and updates to the plan as appropriate. Intervals of periodic review and TP updates should be established based on the severity of the Participant's condition.

Participating parties in the review of the TP with the Contractor's Care Manager Shall include, but not be limited to, the following:

a. Participant/Enrollee, or Participant designee;
b. Case Manager;
c. Provider/Primary Care Physician; and
d. Representatives providing services to the Participant as identified in the TP (e.g. nutritionist or psychiatrist).

Due to the holistic nature of the TP and Assessment that each Enrollee is required to have, the Enrollee Shall have access to a variety of health care disciplines and counseling. The Enrollee must have access to mental health and behavioral health professionals, and nutrition counselors.

At a minimum, the TP Shall take into account:

- Clinical history, including co-morbidities;
- Health status and risk for secondary disabilities or complications;
- Risk level;
- Age;
- Diagnosis/diagnoses;
- Functional and/or cognitive status;
- Mental health;
- Nutrition and weight management;
- Language/comprehension barriers;
- Lifestyle issues;
- Cultural/linguistic needs, preference or limitations;
- Level of intensity of care management;
- Immediate service needs;
- Barriers to care;

- Use of prior authorized services;
- Follow-up schedule;
- Family members/caregiver/facilitator resources and contact information (if appropriate);
- Local community resources;
- Psychosocial support resources;
- Access/availability of needed medical equipment/accessible medical equipment;
- Self-management skills;
- Assessment of progress, including input from family if appropriate;
- Accommodation needs (e.g. appointment time), alternative formats (e.g. Braille, large print, disks, audio, electronic) and auxiliary aids and services; and
- Primary Providers' Plans of Care.

4.4 Coordination/Continuity of Care

The Contractor Shall develop and implement policies and procedures related to establishing relationships, developing Referral processes, and sharing information with the Primary Care Physician (PCP), Provider, discharge planners, facility staff, specialists, and State or Community agencies to enable Participants to access needed services and ensure continuity of care.

If the Contractor recognizes a gap in needed services for a CCM Participant, or the Participant needs help in accessing services through another service system, such as mental health or chemical dependency services, the Contractor Shall assist the Participant by coordinating with Providers in the other systems. The Contractor Shall follow up with the Participant to ensure that needed services have been referred and accessed.

The Contractor Shall track and report on a Monthly basis to the Department the number of instances the Contractor provided assistance with obtaining a Referral to another medical service system. The Contractor Shall establish a plan to assist Participants with health care service Referrals. The plan must be approved by the Department prior to implementation. For more information regarding collaboration with health care Providers in this RFP, go to Section 4.13.

The Contractor Shall ensure continuity of care in collaboration with the Provider/PCP by:

- Coordinating care so that an ongoing course of treatment is not interrupted or delayed due to the change in new Providers;
- Assisting with the transfer of medical record information to new Providers in a timely fashion;

- Assisting with development and implementation of a patient/disease registry capable of being shared with other Providers.
- Monitoring the Referral and follow-up of Participants in need of specialty care and routine health care services;
- Documentation of Referral and follow-up services in Participant's record;
- Documentation in Participant's record of emergency medical encounters with the appropriate follow-up as medically indicated; and
- Documentation and follow-up in Participant's record of planned health care services.

The Contractor Shall develop a process and plan for monitoring an Enrollee's adherence to scheduled medical appointments. Monitoring data Shall be accessible to the Department upon request.

4.5 Transitions Plan

The Offeror Shall describe in its response to the RFP how it will transition Participants from Tier-1 to Tier-2 without interruption of services. The Contractor Shall address the transition of Participants out of the CCM program when the Participant has opted-out of the program and/or due to no longer needing CCM services, or will graduate from the program and therefore no longer meets the high risk or high cost criteria for the program. When a Participant's risk score from the Predictive Modeling methodology is no longer within the predetermined category of risk, as approved by the Department, the Participant will no longer need to receive CCM services and remain in the CCM program.

4.5.1 Disenrollment from the CCM program

The Offeror should also include in the response to this RFP how it Shall handle Participants who are disenrolled on a temporary basis (i.e., they lose Medicaid eligibility for two months, or opt-out and then back in). The Offeror Shall specify criteria, or triggers, for disenrolling a Participant.

Disenrollment from the CCM program Shall occur for any of the following reasons:

a. Participant requests to be disenrolled from the program;
b. Contractor makes five unsuccessful telephonic and face-to-face attempts to contact and/or provide services to an engaged Participant;
c. The Department's written request to the Contractor for Disenrollment;
d. Approval by the Department of the Contractor's written request stating the reason(s) for Participants' Disenrollment, including, but not limited to, a Member who routinely disrupts the Contractor's activities or is abusive to Contractor's staff or Participants;

e. Participant is found to be in an excluded category as determined by the Department (e.g. dual elgibles; enrolled in hospice; qualifies for DM program);

f. Participant becomes ineligible for Virginia Medicaid benefits; or

g. Any other circumstance where the Contractor and the Department agree that it is appropriate to disenroll the Participant.

If a Medicaid FFS Recipient qualifies for the DM, the individual must be discharged from the CCM program. A recommendation of transfer to the DM program must be made by the Contractor in collaboration with the Department.

The Contractor Shall maintain accurate records of Enrollment and transition of Participants within levels of the CCM program, as well as Enrollment and Disenrollment. The Contractor Shall not disenroll Participants from the Virginia Medicaid program.

4.6 Care Management (CM)

The Contractor Shall provide Care Management services to all CCM Enrollees. Care managers must be healthcare professionals that are trained and have experience working with chronically ill patients and their conditions. The Care Manager Shall be a part of a Care Management team. The Care Management Team Shall include health professionals with a diverse knowledge base and experience in physical, mental, and psycho-social health care. For more information on a Care Management team, go to Section 1.1 titled Definitions, in this RFP.

It is preferred that Participants have one CM for the whole length of time in the CCM program.

Care Manager duties are as follows:

a. Participate in the initial comprehensive health care Assessment with the Participant, caregiver, or legal guardian;

b. Participate in conducting a baseline health status and health literacy Assessment including a depression screening approved by the Department;

c. Participate in the development and monitoring of individual treatment plans to promote adherence to medical treatment and guidelines.

c. Educate Participants on identified health needs and self-management activities through group and/or private meetings;

d. Provide each Participant’s Primary Care Physician, if the Participant has one, with at least one contact summary per quarter, which includes information on the Participant’s health status, health literacy, medical adherence Assessment data, depression screen results, activity and status in the CCM program, and any social service or other Referrals;

e. Assist Participants in making contact with Providers and community agencies when appropriate including mental health and substance abuse Providers as required. This Shall include follow-up with Participants and Providers/agencies as necessary to ensure services are accessed;

f. Develop and implement interventions for achievement of treatment plan and care plan objectives. The Contractor Shall use its Predictive Modeling system to assist in designing interventions and determining the appropriate intensity of intervention based on the risk Assessment for each Member;

g. Notify the Department of Participants who continue to show patterns of inappropriate utilization or possible misuse of Medicaid services; and

h. Meet the language needs of non-English speaking Participants by providing bi-lingual staff and/or contracting with a translation service. This includes translation for written materials. Non-English speaking Participants Shall receive a level of service comparable to English-speaking Participants.

4.6.1 Care Management (CM) for Tier-1, High Risk Participants

A face-to-face comprehensive health care Assessment is required. Telephonic contact, mailings, and other avenues are the normal communication and Care Management avenues. But due to the high risk score of these Participants, face-to-face intervention Shall be required for accurate Assessments and to ensure adherence to treatment plans. Face-to-face interaction Shall be determined by the Participant's need; however, at a minimum a face-to-face interface is required for the Initial Comprehensive Assessment and at least every six months, preferably in conjunction with a six month Assessment and treatment plan update.

High risk Participants Shall also be contacted telephonically by the Care Manager at a minimum of once per month; however, schedules for calls are based on Participant's need and may occur more frequently.

The Offeror Shall include with its response to the RFP an outline and description of its Care Management for the tier-1 highest at-risk Enrollees, including the standard mix and frequency of telephonic, mailing, and face-to-face interaction with the Participant.

4.6.2 Care Management for Tier-2, Lower Risk Participants

Telephonic CM Shall be the key avenue for contact and intervention by the CM with the Participant. There may be rare incidents or circumstances that warrant a face-to-face contact with the Participant without the need of transitioning to Tier-1. The Offeror Shall include in its response to the RFP an outline and description of its Care Management for Tier-2 Participants including the standard mix and frequency of telephonic and mailing interaction with the Participant.

4.7 Toll-Free Call Center

The Contractor Shall provide and maintain a Call Center that provides toll-free calls for Providers and program Participants in the CCM program. This is to provide health related support, as described under this RFP. The Call Center Shall be available seven days per week, with minimum hours from 7:00 a.m. to 7:00 p.m. The Contractor Shall also have a process for handling emergency situations or calls outside hours of operation.

The Offeror Shall describe the Call Center in its response to the RFP, including its staff, operational processes for in-coming and out-going calls, the organizational and flow chart for the center, and its physical location, including city and State. The description must include the process for handling after hour emergency situations and calls. Any amount owed on these numbers Shall be the sole obligation of the Contractor.

4.7.1 Communication and Language Needs

The Contractor Shall ensure that the communication and language needs of the Enrollees are addressed. This applies to all non-English speaking Participants and is not limited to prevalent languages. The Enrollee cannot be charged a fee for translator or interpreter services. The Virginia Relay service for the deaf and hard-of-hearing Shall be used when appropriate. The Contractor Shall ensure that Providers/Participants Shall not have to disconnect to access interpreter services. The Call Center Shall provide professional, prompt, and courteous customer service at all times.

4.7.2 Call Center Must:

a. Be located in the USA. It is not required to be located in the Commonwealth of Virginia;

b. Be staffed by multidisciplinary healthcare professionals who are fully trained, have the appropriate licensure/certification for their profession, and are knowledgeable about Virginia Medicaid and FAMIS FFS standards and protocols. Call Center staff must have access to psycho-social and clinical professionals to assist with appropriate calls and inquiries;

c. Be knowledgeable of State, federal, and local resources to assist a Participant;

d. Have the capacity to handle all telephone calls at all times during the hours of operation; and have the upgrade ability to handle any additional call volume. Any additional staff or equipment needs, or expense, Shall be the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment for all hours, including high peak times;

e. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner.

f. Include a capability to track and report information on each call. It Shall have the capability to produce an electronic record to document a synopsis

of all calls. The tracking Shall include sufficient information to meet the reporting requirements in Section 4 of this RFP;

g. Be compliant with Medicaid and FAMIS confidentiality procedures/policies, including HIPAA requirements;

h. Install and maintain its telephone line in a way that allows calls to be reviewed for the purpose of evaluating Contractor performance. The call monitoring by a third party Shall be available to the Department program monitor; and

i. Provide TDD/TDY access.

4.7.3 Call Center Performance Standards

The Contractor Shall be responsible for meeting the following performance standards and is required to provide reports as outlined in this RFP demonstrating that it has met or exceeded the standards:

a. The Call Center Shall be available to respond to inquiries except for down time for which the Contractor has received prior written approval from the Department, excluding acts of God;

b. The Contractor Shall provide sufficient staff, facilities, and technology such that 95 percent of all call line Inquiry attempts are answered. The total number of busy signals and abandoned calls measured against the total calls attempted Shall not exceed ten percent in any calendar week; and

c. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator.

4.7.4 Call Center Reporting

The Call Center Shall have the capacity to track individual Provider and Participant call activity and capture important points covered during the call transaction. The Contractor Shall report individual call activity data to the Department upon request.

The Contractor Shall be able to submit a list of Call Center reports that Shall be provided to the Department on a Monthly, Quarterly, and annual basis. The reports should focus on process and outcome monitors. Depending upon the type and purpose of the report, some will be separated by Participant and Provider.

4.8 Staff Requirements

The Contractor's office Shall maintain normal business hours Monday through Friday, with the exception of recognized State holidays. The Contractor Shall not have an employment, consulting, or any other agreement with a person that has been debarred or

suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State.

The Contractor must meet or exceed URAC and/or NCQA accreditation Core Standards and Disease Management Standards for staffing, staffing requirements, and oversight. Offeror Shall submit a proposed organization chart; resumes of proposed management and key staff, and job descriptions and the requirements of management and key staff positions. Due to the dominating mental and behavioral health diagnosis of the potential Eligibles for the program, the Contractor Shall have a licensed psychologist(s) and psychiatrist(s) on staff and available to the Care Manager and call center.

4.8.1 Staffing Plan Must Include:

a. A Project Director specifically identified and 100% assigned to the Contract and with overall responsibility for the administration of the Contract. The Project Director (PD) Shall serve as the liaison to the Department by communicating with the Department's program manager/program monitor regarding service issues. This person Shall be at the Contractor's Management level. The position Shall be responsible for the coordination and operation of all aspects of the Contract. The individual in this position must be approved by the Department, including upon replacement. The individual will be responsible for the management of the daily operations of the CCM program in an orderly and efficient manner, including such functions as Enrollment, information, services calls, administration, data processing, and data reporting. The PD must be available and be able to respond immediately to requests from the Department's Program Monitor and administration.

b. A physician who is licensed by and physically located in the Commonwealth of Virginia to serve as Medical Director to chair and oversee the Contractor's Quality Assurance Committee to ensure the proper provision of CCM Program services to Enrollees;

c. A Quality Assurance Officer (QAO) to coordinate requirements of the Contract and to oversee routine QA/QI meetings of the Contractor's staff, and to participate in Quarterly QA/QI collaborative meetings at the Department's offices. The QAO may also be the Project Director; and

d. A sufficiently trained and experienced administrative and clinical staff who can address the unique needs of the program's Participants while assuring that services are provided in the most economical manner.

4.8.2 Call Center Staff

Call Center staff Shall consist of qualified, medically trained personnel, whose primary duties are to maintain a toll-free Call Center and "help desk" services to be responsible for assisting Enrollees in answering their health related questions; assisting Enrollees to make appointments and obtain needed services; to handle Enrollee inquiries and Grievances, and other duties related to the Call Center as outlined in this RFP.

4.8.3 Care Management Professionals

The Contractor Shall employ multidisciplinary teams to provide Care Management services. As stated above, staffing roles and requirements must comply or exceed URAC and/or NCQA accreditation Core Standards and Disease Management Standards.

The number of Participants that a Care Manager can be directly responsible for Shall be limited within each tier. The table below gives the ratio between CM and Participant. The Contractor may implement a lower ratio of Care Manager to Participant, but a higher ratio cannot be implemented without prior authorization from the Department.

TABLE D - Care Manager to Participant Ratio Per Tier

Intensity	CM to Participant Ratio Limit
Tier-1	1:150
Tier-2	1:250

The Contractor's staffing plan Shall include the materials and methods used (on-going) for training staff, including the handling of calls in a local Virginia office and the Call Center. The Contractor Shall provide copies of all training materials and a description of methods used for training staff with this RFP submission and Annually thereafter.

The Contractor Shall identify in writing the name and contact information for the Project Director and the Medical Director at the implementation of the program. The Department reserves the right to require the Contractor to select another applicant for any of these positions. The Contractor Shall notify the Department of any changes in these two staff positions during the term of this RFP in writing ten (10) Business Daysprior of a change for approval.

The Department reserves the right to approve or reject rehires to program management level positions. Failure to maintain the required staffing level to meet Contract requirements may result in a reduction in the Department's administrative payments to the Contractor. Reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Contractor. The Contractor Shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level. The Contractor's failure to comply with staffing requirements as described in this RFP Shall result in the application of intermediate sanctions.

4.8.4 Licensure

The Contractor is responsible for assuring that all persons, whether they are employees, agents, Sub-Contractors, Providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision Shall result in

Assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and the Department may terminate the Contract for cause as described in this RFP.

4.8.5 Personnel Evaluation Tools

The Contractor Shall develop and administer performance evaluation tools for Care Management staff, Call Center staff, and other staff that are involved in the care and training of Participants and Providers. These tools Shall be submitted to the Department for approval prior to use. The tools Shall measure various components of the position requirements which demonstrate success in improving Participant outcome measures related to health literacy and management and Provider outcome measures that indicate effective health management.

4.8.6 Training

The Contractor Shall provide training to the Contractor's care managers on current evidence-based guidelines for relevant diagnoses, associated co-morbidities, potential barriers to medical adherence, confidentiality of Participant's personal information, including Health Insurance Portability and Accountability Act (HIPAA) requirements, motivational interviewing, and appropriate interventions to increase adherence. Care managers Shall also receive training on self-management strategies, cultural sensitivity, safety, and behavioral health treatments and Assessments.

The Offeror Shall describe how it will train its Care Management staff on diversity and communicating with complex populations, especially with Participants with some type of behavioral health diagnosis.

The Contractor Shall train all Call Center information services staff appropriately and the training Shall include at a minimum the following:

a. Telephone etiquette;
b. Eligibility and Enrollment verification;
c. Contractor information system;
d. CCM program purpose, features, eligibility, services, and Enrollment;
e. Basic information about Virginia Medicaid State Plan benefits and Enrollment;
f. Referral information sources and follow-up procedures;
g. Call types which must be referred to a licensed nurse;
h. Documentation procedures; and
i. Maintenance of Medicaid Participant confidentiality, including HIPAA.

4.9 Contractor's Information Platform Systems

The Contractor is responsible for a fully integrated Chronic Care Information Platform System (CCMIPS). It is the Contractor's responsibility to maintain the CCMIPS' operations, and compatibility with other necessary systems. The Contractor is also responsible for maintaining peripheral hardware, software, and other items as needed to comply with the Contract.

4.9.1 Contractor's Chronic Care Management Information Platform System

The Chronic Care Management Program Administrator/Contractor Shall operate and maintain an information system that allows maintenance of demographic and clinical information on patients, tracking and monitoring of patients, communication with care managers, setting up reminders and recalling tasks, and development of needed reports for office practice.

The Contractor Shall maintain a HIPAA compliant database and patient registry in a format acceptable to the Department that is capable of recording and maintaining Participant Protected Health Information (PHI) and for retrieving data on short notice.

The information system may include a web-based component for communication and collaboration between the Contractor and the Providers, between the Contractor and Participants, and between the Contractor and the Department. Such a segment of the system would allow access to reports, records, and other information on a Participant's case for the purpose of aiding all parties in the quality and quantity of healthcare of the Participant. Due to various levels of information privacy and relevance there should be separate levels of accessibility to information for the various parties. The various access level platforms Shall be in a user-friendly format and information and reports Shall be updated for all accessible parties. This segment of the Contractor's information system Shall be independent of the Department's website, but with links to and from the Department's website.

The information platform system Shall include, but not be limited to, program information related to Participants, such as eligibility requirements, status of Participants, Enrollment, services, and other essential Participant data. The information platform system Shall also include Provider information and other essential contact names, telephone numbers, and addresses necessary for a Participant's service(s).

4.9.2 Data Elements for the Contractor Database

The data elements listed below Shall be included in the database. The database also may include other elements.

a. Enrollee Name;

b. Medicaid or FAMIS ID #;

c. Enrollee Social Security Number (SSN);

d. Enrollee address and phone number;

e. Enrollee's Disease/Condition(s) and diagnoses;

f. Date Enrollee was sent outreach materials;

g. Date Enrollee refused CCM program or accepted CCM program and why;

h. Enrollee's Primary Care Provider name and Medicaid Provider name and telephone number;

i. List of Participants healthcare service Provider(s);

j. Health Assessment Information, to include:

- Date Assessment conducted;
- Goals established;
- Medicaid Provider names and Medicaid Provider numbers;
- All dates and types of Referrals made, if requested;
- All Care Management contacts made, and outcome of contacts;
- Any other data element required by common practice, Department guidelines, federal or state law;

k. A Participant's risk score and assigned level of care;

l. Date, type, Enrollee name of telephonic contacts; and

m. Dates of all face-to-face contacts with Participants.

Data stored in the database Shall be current through the prior quarter processing of Medicaid claims data. The Virginia-specific CCM program data stored in the Contractor's database Shall be the property of the Department.

4.10 Predictive Modeling (PM) Tool

The Contractor must provide a validated Predictive Modeling methodology that is appropriate and optimized on Medicaid diseases and related care issues for Medicaid populations, and is based on future predicted costs vs. current costs. The methodology must include current actual costs and expected cost models for baseline information, program evaluation, and Provider profiling. The Contractor must be able to show validation testing results.

Therefore, the Offeror Shall submit with its response to this RFP evidence that the Predictive Modeling methodology and tool is:

a. Appropriate and optimized on Medicaid diseases and related care issues for Medicaid populations;

b. Based on future predicted costs and not current costs;

c. Including current actual costs and expected cost models for baseline information, program evaluation, and Provider profiling; and

d. Able to show validation testing results.

The methodology must be approved by the Department. The PM tool may be provided by the Offeror itself or through a Subcontract with another entity.

At a minimum, the Predictive Modeling program Shall:

a. Receive claims and eligibility data from the Department into a data warehouse. The data warehouse must be configured to receive data as the Department's current system allows, as the system cannot be configured to meet the Contractor's specifications. Data will be extracted from the Department's fiscal agent's data warehouse;

b. Identify patterns of care that are likely to lead to higher (preventable) costs. These patterns of care should be mapped to specific interventions that would be expected to improve health outcomes and control costs. This includes:

   - Identify evidence-base for care gap analysis;
   - Identifying Participants receiving inadequate care for chronic conditions, including medical, mental health, and substance abuse;
   - Identifying Participants receiving contra-indicated medications;
   - Identifying Participants who use the Emergency Department with conditions that could be treated in primary care settings;
   - Identifying Participants who have been hospitalized with complications of medical conditions and the hospitalizations could have been avoided with proper care management; and
   - Identifying and prioritizing Participants whose conditions can be positively affected or better controlled by Care Management vs. those whose conditions cannot;

c. Perform basic "risk scoring" tasks, which include physical/clinical elements, but also psychosocial, mental health, and behavioral elements. Explain how risk weights and scoring system were determined;

d. Identify the relative risk (using the "risk scoring") that a Participant demonstrates for the "high intensity Tier-1" Care Management or "lower intensity Tier-2" care management, and define the sensitivity and specificity for the two different tiers.

e. Assess prospective health care risk and not just current risk;

f. Provide information to help estimate the potential cost impact of implementing interventions to improve care. The cost impact information could be accomplished by comparing utilization and costs for otherwise similar Participants receiving "good care" and "poor care" in historical claims data, using standardized definitions of quality of care (for example, HEDIS-like measures). The tool should allow specification of matching criteria for comparison groups (This must be a sound and proven method as such comparisons can be made for evaluations. Poorly constructed

comparison groups can be a source of erroneous information leading to poorly informed decision making);

g. Recognize service gaps in care for Participants; and

h. Report on the enrolled population and utilization of services.

While the Predictive Modeling tool may be considered proprietary, the Department must be allowed to review all programming logic and algorithms built into the model.

The Offeror Shall submit a description of it Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines. The Offeror Shall submit specifications and a performance report on the Predictive Modeling tool that will be used. The report Shall include:

- A brief history of the tool's development and historical and current uses;
- Medicaid data elements to be used for predictors and dependent measure(s); and
- Assessments of data reliability and validity.

The Offeror Shall also submit with its response to this RFP a description of how the rules and strategy to achieve projected clinical outcomes and how clinical outcomes Shall be measured.

The Offeror Shall also describe how the model has been optimized on the type of interventions and the constraints on intervention to the Medicaid program and population.

4.11 Virginia Medicaid Management Information Systems (VAMMIS) Requirements

In response to this RFP, the Offeror must demonstrate the ability to interpret, map, and load into the Offeror's electronic systems data received from the Department that was extracted from the Virginia Medicaid Management Information System (VAMMIS) operated by the Department's fiscal agent, First Health Services Corporation (FHSC). The Contractor may also be required to provide data and other information to the Department (as required) to be used for monitoring and analysis. The Contractor must successfully test all aspects of data transference.

4.11.1 Contractor's Data Transference from the Fiscal Agent

The Contractor may not transmit PHI over the Internet or any other unsecured or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 164.308(e). If the Contractor stores or maintains PHI in encrypted form, the Contractor Shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

The Department will provide technical assistance to the Contractor to ensure that appropriate transference of data occurs from the fiscal agent.

All expenses incurred in establishing the data transference between the Contractor and the Department's fiscal agent Shall be the responsibility of the Contractor. The Contractor must have successfully loaded the electronic data received from the Department at least 60 days prior to implementation.

The Contractor is expected to comply with the Health Insurance Portability and Accountability Act (HIPAA) Final Rules and Standards related to the electronic transactions of data between the Contractor and the Department, and transmission within and out of the Contractor's corporate network including any internet service Providers (ISP). These HIPAA standards involve:

1) The Privacy of Individually Identifiable Health Information;
2) Standards for Electronic Transactions; National Standards for Employer Identifiers;
3) National Standards for Health Care Provider Identifiers; and the
4) HIPAA Privacy and Security Regulations.

4.11.2 Interfaces

The Contractor Shall not have direct access to VAMMIS. The Contractor is expected to conduct all processing on its own hardware and software and must be able to receive and load the data files to be used for the sole purpose of predictive processing and necessary functions for CCM eligibility determination, Enrollment, and Care Management functions for Virginia Medicaid eligibility and claims data.

From the interfaces provided, the Contractor Shall complete all data mapping necessary to perform CCM responsibilities, including the submission of information to the Department and respond to information provided by the Department at no cost to the Department. This will consist of a cross-reference map of required VAMMIS data and Contractor system data elements and data structures. The Department will use existing data formats (to be provided to those interested parties that submit the required letter of intent) as much as reasonably practicable as determined by the Department and make the data formats available to the Contractor upon award.

4.11.3 Claims and Eligibility Data

The Contractor Shall receive (pull) and process Recipient eligibility and claims data from the Department via a File Transfer Protocol (FTP) file. This data will include all paid claims processed within the determined period. The Contractor Shall receive updated eligibility data on a Monthly basis, and claims data on a Quarterly basis.

An initial Recipient data load is to be completed after the Contract has been awarded and prior to the CCM implementation date, and all subsequent Monthly and Quarterly processing would replace this initial data. The Department will provide the data in a specified file format and the format Shall be non-negotiable. No other claims data will be made available for relationship analysis.

4.11.4 Contractor Electronic Access to Department Data

The Contractor Shall "pull" all data for the target population as described in Section 3.1 from the Department in a HIPAA compliant fashion by secure electronic file transfer protocol (FTP). The Department's fiscal agent will require the execution of a trading partner's agreement for the FTP connection. The Contractor Shall describe in detail their secure FTP connectivity. All expenses incurred in establishing connectivity between the Contractor and FHSC Shall be the responsibility of the Contractor. The FTP access to the fiscal agent must be fully operational thirty days prior to implementation.

4.11.5 Secure FTP Requirements

The Contractor is to access the FHSC Secure File Transfer Server over the Internet. This process supports the FTPS (SSL FTP/AUTH SSL) protocol to secure all communications between the Contractor and the server. An area on the server will be created for the Contractor to get files.

FHSC supports Secure Sockets FTP over the Internet that complies with RFC 959, 1123, and 2228. The Contractor is required to use a 128-bit SSL client software package, at the Contractor's expense that supports passive mode. FHSC also supports PGP.

4.11.6 Contractor Database and Processing System

In addition, the Contractor must provide the Department with remote access (read-only) to the Contractor's computer system with respect to all Virginia Medicaid requirements/activities. In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, the Contractor Shall maintain a HIPAA compliant database, in a format acceptable to the Department and utilizing the MMIS Provider, Recipient, and claims and encounter data received via the FTP process. The database Shall be capable of maintaining and recording Participant Protected Health Information (PHI) for the Department's auditing functions; and retrieving data on a short notice. Data stored in the database Shall be current on a Monthly and Quarterly basis, based on the updates received from the Department's fiscal agent and the Contractor's interaction with that data and should be routinely backed up either manually or with appropriate software. This system Shall be capable of allowing for future growth in service volume.

Although the Contractor Shall maintain the database and processing system at their Facility, the Department will have access to the database and the MMIS specific data stored.

4.11.7 DMAS/The Department's Remote Access/Email Communications

For any e-mails sent to the Department with PHI information, the Contractor Shall provide SSL secure email access over the Internet between the Department and the Contractor. The preferred method is end-to-end TLS ESMTP email Encryption of at least 128-bits between the Contractor's ESMTP email server and the Department edge mail security appliances. Bidirectional TLS email Encryption must be tested and documented between the Department and the Contractor's SMTP server. The Contractor's email coming from or going to the Department must otherwise pass through encrypted or dedicated line connections to any other corporate units. Otherwise, the Contractor Shall use the Department secure email server encrypted at 128-bits for secure email. The Department uses Tumbleweed secure email server for all secure email between the agency and outside entities not connected to the Department by dedicated lines. The Department additionally has implemented the new Symantec Mail Security appliances that do point-to-point TLS email Encryption.

4.11.8 Web Provider Access

If the Contractor allows Providers to remotely access and respond to audit inquiries through the web, the Contractor's function must be in a secured environment using an application via a web browser from the Provider's computer/workstations with the same standards designated for the Department.

4.11.9 Communication Plan

The Contractor Shall be expected to provide the Department with a written Communications Plan and flow diagram to include communications security that describes the use of data that will be sent to the Department or FHSC or reside in the custody of the Contractor and how that data is accessed. The Contractor must submit the initial Communications Plan to the Department sixty (60) days before the date of implementation and must include a connectivity flow diagram. If any changes occur during the Contract period, the Contractor must submit an updated Communications Plan to the Department within ten (10) business days after the change occurred and must include an updated connectivity flow diagram. The Contractor Shall submit the revised Communication Plan to the Department at least ten (10) business days prior to its implementation for approval and to allow the Department to make any necessary adjustments or changes.

4.11.10 Systems Readiness Review

The Contractor Shall work with the Department to ensure that the Contractor's processing system satisfies the functional and informational requirements of Virginia's CCM program. The Contractor Shall assist the Department in the

analysis and testing of the data and information transfer prior to the date of implementation. The Contractor Shall provide any software or additional communications network required for access at the Contractor's expense.

4.11.11 System Security

The Contractor Shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in an Information Security Plan. The risk analysis Shall also be made available to appropriate Federal agencies.

The following specific security measures should be included in the system design documentation and operating procedures:

- Computer hardware controls that ensure acceptance of data from authorized networks only;
- At the Contractor's central Facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
- Manual procedures that provide secure access to the system with minimal risk;
- Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel;
- All Contractor database software changes related to this Contract may be subject to the Department's approval prior to implementation; and
- System operation functions must be segregated from systems development duties.

The Information Security Plan document must be delivered to the Department sixty (60) days before date of implementation. If any changes occur during the Contract period, the Contractor must submit an updated Information Security Plan to the Department within ten (10) business days after the change occurred.

4.11.12 Disaster Preparedness and Recovery at the Processing Site

The Contractor must submit a copy of its Business Continuity/Disaster Recovery plan for its processing system. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the Contract's implementation and must meet the requirements of any applicable state and federal regulations, and of the Department. The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements:

- Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, or other incidents such as sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor Shall apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to perform all functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's disaster plan must include provisions in relation to the telephone number(s);
- Employees at the site must be familiar with the emergency procedures;
- Smoking must be prohibited at the site;
- Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel;
- Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
- The site must be protected by an automatic fire suppression system; and
- The site must be backed up by an uninterruptible power source system.

The Business Continuity/Disaster Recovery Plan document must be delivered to the Department sixty (60) days before implementation.

4.11.13 Data Completeness

The Contractor Shall ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, Call Center and outcome reports Shall be submitted via electronic media or via the web in accordance with Department criteria.

In the event that electronic data files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within thirty (30) calendar days.

4.12 Participant Education and Outreach

The Contractor Shall design, produce and distribute, via the United States Postal Service, various types of Enrollee materials, including but not limited to brochures, Provider directories, fact sheets, notices, or any other material necessary to provide information to Enrollees as agreed upon and required by the Contract resulting from this RFP, and Shall bear all costs related to this activity. In response to this RFP, the Contractor Shall submit, as examples, copies of materials utilized in contracts of a similar scale to address the requirements outlined in this RFP.

In addition, the Contractor Shall:

a. Mail all Eligible Enrollees of the CCM program an introductory letter informing them that the CCM is a part of their Virginia Medicaid benefits;

b. Provide educational materials to all CCM Participants targeted to their condition(s) and level of intensity determination;

c. Mail Participants appropriate follow-up letters regarding their program status, compliance, and utilization of services; and

d. Respond to mail inquiries from Participants.

The Contractor may distribute additional materials and information, other than those required by this Section, to Enrollees in order to promote health and educate Enrollees. Any costs of additional services provided above the base requirements Shall be listed separately in the Offeror's Cost Proposal.

All materials sent to Enrollees and Enrollee communications including form letters, mass mailings, and system generated letters, whether required or otherwise, Shall require written approval by the Department prior to dissemination as described herein and Shall be designed and distributed in accordance with the minimum requirements of this RFP. Letters sent to Enrollees in response to an individual query do not require prior approval. The required Enrollee materials include the following:

4.12.1 CCM-Potential Enrollee Information

The Offeror Shall include with its response to this RFP its plans to educate CCM-potential Enrollees about the CCM program and how the Offeror Shall disseminate such information. CCM-potential Enrollees Shall be notified within ten (10) days of identification by the Contractor that they are Eligible for CCM program services.

Marketing materials for potential Enrollees Shall:

- At a minimum be in accordance with all applicable requirements described in this RFP;
- Include information about CCM services and a clear statement that these services are available at no cost and without cost sharing responsibilities, thereby having no effect on a Participant's Medicaid eligibility; and
- List the toll-free Call Center number (or another number, if the Contractor specifies) and website access, if available, for the Contractor with a statement that the individuals may contact the Contractor regarding questions about their care under the program.

4.12.2 Prior-Approval Process for CCM-Enrollee/Participant Materials

The Contractor Shall submit to the Department's Contract/Program Monitor a detailed description of any materials it intends to use and a description of any activities prior to implementation or use. This includes, but is not limited to, all policies (including confidentiality) and manuals, advertisement copy, brochures,

posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, letters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.

The Department Shall review the Contractor's materials and approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission. Once the Department has approved the materials, the Contractor Shall submit one (1) electronic copy of the final product to the Department's CCM Contract Monitor. Some problems may not be evident from the materials submitted, but may become apparent upon use. The Department reserves the right to notify the Contractor to discontinue or modify materials or activities after approval.

4.12.3 Written Material Guidelines

The Seal of the Commonwealth of Virginia Shall not be used on communication material without the written approval of the Department. All written materials Shall:

a. Be worded at a 6th grade reading level, unless the Department approves otherwise;
b. Be clearly legible with a minimum font size of 12 pt. unless otherwise approved by the Department;
c. Be printed with an assurance of non-discrimination;
d. Be translated and available in Spanish. Within ninety (90) days of notification from the Department all vital documents Shall be translated and available to each Limited English Proficiency group identified by the Department that constitutes five percent (5%) or more of the CCM program population;
e. Be printed at an appropriate health literacy level and conform to health literacy guidelines regarding complexity and formatting; and
f. Be made available in alternative formats upon request by persons with disabilities and appropriate interpretation services Shall be provided by the Contractor.

The Contractor Shall develop printed materials for Enrollees that reinforce the face-to-face and telephonic communication from the Contractor.

The Contractor Shall provide written notice of any changes to CCM Participants in policies or procedures described in written materials previously sent to Enrollees. The Contractor Shall provide written notice at least thirty (30) days before the effective date of the change.

The cost of design, printing, and distribution (including postage) of all Enrollee materials Shall be borne by the Contractor.

The Contractor Shall comply with all Federal postal regulations and requirements for the mailing of all materials. Any postal fees assessed on mailings sent by the

Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations Shall be borne by the Contractor and at no expense to the Department.

4.12.4 Failure to Comply with Enrollee Material and Communication Requirements

All CCM materials Shall adhere to the requirements as described. Failure to comply with the communication limitations/standards contained in this RFP, including but not limited to the use of unapproved and/or disapproved processes and communication materials, may result in the Department imposing one or more of the following, which Shall remain in effect until such time as the deficiency is corrected:

a. Revocation of previously authorized communication methods; and/or

b. Application of sanctions. Sanctions may include, but not limited to, reprimands by the Department, monetary penalties, and/or termination of Contract. See Section 11.8 of this RFP for additional information.

4.13 Enrollee Grievance to the Contractor

The Contractor Shall have a Grievance process in place available to Enrollees who wish to file a Grievance. This process must assure that appropriate decisions are made as promptly as possible. The Contractor Shall develop policies and procedures regarding the Grievance processes. These must be reviewed and approved by the Department prior to implementation. The Contractor Shall provide the Department with Monthly reports indicating the number of Grievance requests received as well as a detailed analysis, disposition of each Grievance, and a corrective action plan.

4.14 Collaboration with Providers

The Contractor Shall collaborate with the healthcare Providers of each Participant and specifically with the Primary Care Physician. Collaboration with Providers includes, but Shall not be limited to:

a. Communication with Providers to inform them of the CCM Member's Enrollment, status, and participation in the program. A Participant's Primary Care Physician must be notified immediately upon the patient's Enrollment into CCM. Other healthcare Providers that are actively rendering healthcare services to the Participant Shall be notified;

b. Collaboration in the development of a holistic Assessment of the Enrollee;

c. Collaboration of the development of the treatment plan/plan of care;

d. Provision of updates on the Participant's condition;

e. Provision of relevant utilization data on the Participant that would assist the Provider;

f. Online information applicable to appropriate Providers; and

g. Provision of education as described in Section 2.9.1.

The Offeror Shall submit with its response to this RFP how it will develop either partnerships or working relationships with healthcare Providers and medical and advocacy groups for the collaboration of improving the quality of care of the Participant. This includes collaborating with community service programs to provide information and resource directories to the Participants.

Home and Community Based Waiver Providers

There are seven waivers administered by the Commonwealth of Virginia. More information on the Department's waivers can be found in ATTACHMENT IX.

- Elderly or Disabled with Consumer Direction (EDCD);
- Individual and Family Developmental Disabilities Supports (IFDDS);
- HIV/AIDS;
- Technology Assisted (Tech);
- Mental Retardation (MR);
- Day Support; and
- Alzheimer's Assisted Living (AAL) Waiver managed by the Facility and Home Based Care Unit.

Five waiver programs are managed by the Department of Medical Assistance Services. The Department's Division of Long Term Care is responsible for the development, oversight, and quality management review of these waivers. The Department's staff responds to requests for policy interpretation, prior authorization services, and technical assistance to Providers.

The Contractor Shall support treatment and care from waiver Providers. The Contractor Shall collaborate with the waiver Providers in the recruitment, Enrollment, Assessments, development of treatment plans, and Disenrollmentform the CCM program.

All of the waivers have case managers accept the EDCD waiver. The Contractor Shall collaborate with the waiver case managers. Along with waiver case managers, the Contractor Shall collaborate with Mental Health case managers.

4.14.1 Medallion Primary Care Case Managers

The Department provides Medicaid to individuals through three programs: a managed care program utilizing contracted managed care organizations (MCO) and a primary care case management program (PCCM) called MEDALLION or fee-for-service (FFS), which is the standard Medicaid program. The SCHIP program, Family Access to Medical Insurance Security (FAMIS), is not a Medicaid program; however, it is administered through both the FFS and

managed care delivery systems. The Contractor Shall collaborate with a CCM Participant's Medicaid Providers in Assessments, treatment plans, and other health and behavior related care.

Family Access to Medical Insurance Security (FAMIS)

There are approximately 7,625 total SCHIP/FAMIS Enrollees in Virginia. Out of this total, approximately 6,571 individuals are enrolled in a FAMIS Fee-For-Service (FFS) program, and therefore are Eligible for CCM. The remaining approximate 1,054 children are enrolled in a Managed Care Organization and are exempted from the CCM program. Some of these children in the FAMIS FFS program may be enrolled with a Primary Care Provider. If a CCM Enrollee is receiving FAMIS FFS services and has a (PCP), the Contractor is responsible to notify the PCP of CCM Enrollment. The Contractor should collaborate with the FAMIS Enrollee's PCP in the development of the treatment plans and other necessary changes that directly affects the PCP's responsibilities. If a FAMIS Enrollee has a PCCM, the CCM Care Manager Shall be responsible to collaborate with the PCCM in the Assessment of the Participant's needs; in the development of the Participant's treatment plan; and other Care Management duties relevant to the PCCM.

For more information on FAMIS and Management Care Organizations in Virginia, see Attachment VI.

The Contractor's CCM Care Manager is the primary Care Manager for services and treatment plans.

4.14.2 Provider Education

The Contractor Shall provide Quarterly mailings to all Medicaid Providers who participate in the health care of a CCM Participant. Mailings Shall include, but may not be limited to:

a. Educational material on the CCM program;
b. Educational material on evidence-based guidelines, practice management and care process information, and other health management information;
c. Materials for accessing and utilizing the Contractor's web-based information system;
d. Prevention in primary care;
e. The Chronic Care Model; and
f. Information on collaborative training sessions organized, planned, and administered by the Contractor.

The sessions Shall be designed to bring together Providers dedicated to improving chronic and preventive care and to promote partnerships within the Provider community. These sessions Shall be designed to develop consensus support for

evidence-based guidelines and improve long-term health care outcomes in the treatment of the Medicaid population.

The Contractor Shall provide one (1) statewide conference within the first year of operation as the Contractor, and nine (9) to twelve (12) regional collaborative meetings in the following twelve (12) months thereafter. The collaborative meetings Shall focus on the following:

i. Support self-management efforts of patients with chronic conditions;

ii. HEDIS or HEDIS-like measures used by the Contractor in the CCM program;

iii. Process involved in CCM Assessments and the development of treatment plans;

iv. Communication and collaborating with the Contractor; and

v. Peer-to-peer discussion of chronic care and health management practices.

The Contractor Shall ensure that all collaborative training sessions including the statewide conference qualify for continuing medical education (CME) credits for physicians and other clinical professionals.

4.15 Sub-Contractors

The Department encourages the Contractor to use local or regional Sub-Contractors when appropriate and available to provide face-to-face Care Management services and Provider education. The Contractor may also propose other methods of involving local and regional entities in health management initiatives and creating a long-term, sustainable health management effort for Medicaid Participants. The involvement of local and regional organizations is not mandatory, but a respondent's plans and approaches to involve these entities may impact its proposal score.

4.15.1 Legal Responsibility

The Contractor Shall be responsible for the administration and management of all aspects of this RFP and the CCM program covered there under. If the Contractor elects to utilize a Sub-Contractor, the Contractor Shall ensure that the Sub-Contractor Shall not enter into any subsequent agreement or Sub-Contracts for any of the work contemplated under the Subcontract for purposes of this RFP, without prior approval of the Contractor. No Subcontract or other delegation of responsibility Shall terminate or reduce the legal responsibility of the Contractor to the Department to ensure that all activities under the Contract are carried out.

4.15.2 Prior Approval

All Sub-Contracts, amendments, and revisions related to the Contract Shall be approved in advance by the Department. All Sub-Contracts Shall be maintained in accordance with the applicable terms of this RFP. Once a Sub-Contract has been executed by all of the participating parties, a copy of the fully executed Sub-Contract Shall be sent to the Department within 30 days of execution.

4.15.3 Notice of Sub-Contractor Termination

When a Sub-Contract that relates to the provision of CCM program services to Participants is being terminated between the Contractor and a Sub-Contractor, the Contractor Shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice Shall include, at a minimum, a Contractor's intent to change to a new Sub-Contractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor Shall also provide the Department with a transition plan, when requested, which Shall include, at a minimum, information regarding how continuity of care Shall be maintained for the Participants. The Contractor's transition plan Shall also include provisions to notify impacted or potentially impacted Participants of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including Sub-Contract requirements may result in the application of intermediate sanctions. The Department reserves the right to require this notice and procedures for other Sub-Contracts if determined necessary upon review of the Sub-Contract for approval.

4.15.4 Notice of Approval

Approval of Sub-Contracts Shall not be considered granted unless the Department issues its approval in writing (to include e-mail). The Department may revoke such approval if the Department determines that the Sub-Contractors fail to meet the requirements of this RFP/Contract.

4.15.5 HIPAA Requirements

To the extent that the Contractor uses one or more Sub-Contractors or agents to provide services under this Contract, and such Sub-Contractors or agents receive or have access to Protected Health Information (PHI), each Sub-Contractor or agent Shall sign a Business Associate Agreement with the Contractor that complies with HIPAA. The Contractor Shall ensure that any agents and Sub-Contractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor pursuant to this RFP. The Department Shall have the option to review and approve all such written agreements between the Contractor and its agents and Sub-Contractors prior to their effectiveness.

4.16 Quality and Appropriateness of Care

The Contractor Shall prepare, for the Department's approval, a written description of a Quality Monitoring /Quality Improvement (QM/QI) program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of CCM services.

The Contractor Shall measure utilization of medical services, preferably using HEDIS performance measures, but it may use HEDIS-like measures when appropriate. (All HEDIS-like measures must be approved by the Department prior to being used.) Measures should include, at a minimum, the number of hospital admissions and readmissions, the number of emergency room visits, and ambulatory visits. The Offeror Shall include in its RFP response a sample of the measures that will be used.

The Contractor is encouraged to perform all Medicaid HEDIS performance measures as a part of the QI program. The Contractor Shall, at a minimum, complete the following Medicaid performance studies/measures, including quantitative measurement data:

- Preventable hospitalizations
- Follow-up after hospitalization for mental illness; and
- Antidepressant Medical Management

4.16.1 At a minimum, a QA/QI plan Shall include:

a. Methods for establishing baseline measures and monitoring changes and trends over time;

b. Approaches to identifying and correcting quality problems;

c. Methods for follow-up of potential quality-related issues, including Referrals to the Department;

d. The role and composition of the Quality Assurance/Quality Improvement Committee and regularly scheduled meetings;

e. The role of the Contractor's Medical Director in the Quality Management/Quality Improvement (QM/QI) program; and

f. The role and responsibilities of the Contractor's Quality Assurance Officer.

4.16.2 Evaluation Methods

The Contractor Shall use at a minimum HEDIS® data specifications. Evaluation methods Shall include the following (unless otherwise specified, all measures are collected by the Contractor, reported to and analyzed by the Department):

a. For Participant diseases and conditions, the Contractor Shall be asked to identify all clinical outcomes that Shall be used to measure improvement in adherence to evidence-based guidelines for care. These clinical variables and outcomes Shall be measured for Participants at baseline and at 11 months;

b. The Contractor Shall report health processes and outcome indicators that will be used to measure improvements in adherence to evidence-based guidelines for care and care coordination. These indicators will be measured for the Enrollee population at baseline and at 12 months intervals thereafter;

c. The Contractor Shall measure net savings by developing a Predictive Model of expected expenditures (the methodology must be approved by the Department) and comparing the expected expenditures to actual expenditures less program costs. Health care expenditures include inpatient hospital, outpatient hospital, physician, pharmacy, lab and x-ray expenditures. All CCM-Eligibles identified by the Contractor Shall be included in the analysis; and

d. The Contractor Shall provide data broken out by specific sub groups (e.g., children and adults).

4.16.3 Evaluation of Program Goals

The Offeror Shall submit its proposals of internal measures for evaluating its progress in reaching and meeting program goals. The Contractor Shall cooperate with the Department and its selected evaluator in conducting an external evaluation of the CCM Program by providing data and information about the Contractor's CCM program. The Department-contracted evaluator Shall use the Contractor's data to validate baselines and other Contractor-collected data, outcomes of the Contractor's specified CCM interventions, and the achievement of expected benchmarks of success.

Additionally, upon mutual agreement between the Department, the Contractor and the Department-contracted evaluator, the Contractor Shall provide additional data as requested. The Contractor is required to cooperate with an independent Assessment/evaluation process, and share its methodology and data with the Department-contracted evaluator.

The data that the Contractor Shall provide to the evaluator will include, but is not limited to:

- Number and nature of contacts/interventions with Enrollees;
- Risk-assignment process and related interventions; and
- Contractor's Assessment methods and Enrollee responses to standardized questionnaires, Assessments, and surveys.

The Contractor Shall cooperate with any performance review conducted by the Department, including providing copies of all records and documentation arising out of the Contractor's performance of obligations under the RFP. Upon reasonable notice, the Department may conduct a performance review and audit of the Contractor to determine compliance with the RFP. At any time, if the Department identifies a deficiency in performance, the Contractor Shall be required to develop a corrective action plan to remediate the deficiency including

an explanation of how Enrollees Shall continue to be served until the deficiency is corrected.

4.16.4 QM/QI Meeting Requirements

The Contractor Shall notify the Department CCM Program Administrator and/or Contract Monitor of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee with ten (10) calendar days advance notice. These meetings may take place in a conference call format provided by the Contractor. To the extent allowed by law, the CCM Program Administrator and/or Contract Monitor of the Department, or his designee, may attend or listen and participate in the QM/QI meetings at his option. In addition, written minutes Shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting Shall be provided to the Department. See Section 4.19.4 of this RFP for more information on a QM/QI meeting reports.

4.17 Policies and Procedures

The Contractor Shall provide Annually, or more frequently as revisions occur, a written copy of its CCM program policies and procedures to the Department for approval. The Department Shall have thirty (30) calendar days to review and approve or request modifications to the policies and procedures. Should the Department not respond in the required amount of time, the Contractor Shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely Shall not preclude the Department from requiring the Contractor to respond or modify the policy or operating guideline prospectively.

4.18 Meetings and Reporting Requirements

The Contractor and the Department Shall meet on a weekly, Monthly, and Quarterly schedule. The Contactor Shall collaborate with the Department in the setting of the agenda for these meetings. The Contactor's Project Director (PD) is required to attend and participate in all of these meetings. If the Department's Program Monitor is not able to attend, another Contractor officer Shall substitute. The format, agenda, and platform (telephonic or face-to-face) location of the meetings Shall be a collaborative effort of the Contractor and the Department and must be approved by the Department prior to all meetings.

The Contractor Shall maintain data necessary to complete reports specified in this RFP. The Offeror Shall submit samples of the following types of reports with the RFP response:

- Project Implementation Work Plan;
- Annual Report; and a
- Clinical Outcomes Report;

Reports Shall be transferred electronically to the Department as determined by the Department. Reports that contain Protected Health Information (PHI) Shall be transferred via a File Transfer Protocol (FTP) file. The Contractor Shall not publish any reports or data on the CCM program without prior approval from the Department.

Overview of Required Reports

Name	**Frequency**	**Format & Content**
Weekly Implementation Work Plan Status Report	Weekly, begins two weeks after the Contract has been awarded.	Narrative and data with updated plan of operation, and issue tracking document.
Weekly Status Report	Weekly for first six months. Begins two weeks after the Contract has been awarded	Narrative and data with updated plan of operation, and issue tracking document.
Monthly Status Report	Monthly, beginning the 6th month for six months.	Narrative and data with updated plan of operation, and issue tracking document.
Outreach and Participation Report	Quarterly	Data and narrative description of activities and results.
Call Center Activity Report	Bi-Monthly for the first three months & Monthly thereafter, & when requested	Data format and Narrative explanations.
QM/QI Meeting Report	Quarterly	Narrative with applicable data.
Participant Satisfaction Surveys	Annual	Conducted by third-party. Data table and narrative.
Provider Satisfaction Survey	Annual	Conducted by third-party. Data table and narrative.
Grievance Report	Monthly	Data table and narrative
Annual Report	Annually	Narrative including quantitative data and incorporating other reports.
General Assembly Report	Annually, submitted by August 15th of each year	Narrative, table, data overview.
Clinical Outcomes Report	Annually	Compared to the health status baseline to reflect Participants' health status and behavior modifications.
Utilization and Health Care Monthly Expenditures Report	Annually	Financial savings and narrative.
Fraud and Abuse Report	Within two (2) Business Daysof initiation of any investigative action by the Contractor	Narrative and data.

4.18.1 Status Reports

Weekly Implementation Status Report:

Beginning two weeks after the Contract has been awarded; the Contractor Shall submit weekly status reports of its implementation work plan. The reports should be keyed to the implementation portion of the Contractor's work plan of operations and include, at a minimum:

a. The number of potential Enrollees;

b. The number of contacts made to potential Enrollees;

c. The number of individuals enrolled;

d. The number of individuals who have opt-in and will be assessed;

e. The number of Enrollees, separated by the week;

f. The number of individuals who declined Enrollment after an Assessment;

g. The number of potential Enrollees who are undecided regarding Enrollment;

h. An Assessment of progress made, including the status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project;

i. Target dates for completion of remaining or upcoming tasks/activities;

j. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays;

k. Difficulties encountered in the operations of the CCM program;

l. Recommendations for addressing the problems, and changes needed to the current plan of operation; and

m. Any revisions to the overall work schedule and process.

Additional reporting is required during this period. A detailed Project Implementation Work Plan Shall be submitted to the Department and include a pre-testing of the Call Center (Section 4.7), the Predictive Modeling tool (Section 4:10), and the Contractor's Information Platform System (Section 4:9). Additional information and requirements in this report can be found in Section 8.5.6 of this RFP.

Weekly Status:

After implementation of the CCM program, the Contractor for the first six months of the Contract Shall provide written progress reports and submit them to the Department every week. The reports Shall be due each Monday by 9:00 a.m. It Shall contain the following:

a. The number of initial Assessments completed;

b. The number of times Participants were contacted, how often they were contacted, and the outcome of the contact;

c. Any contacts made on behalf of the Participant to Providers, physicians, and the reason why;

d. Participant or Provider complaints and their resolution(s);

e. Contact dates between the Contractor and the Participant;

f. The number of Participants in each level of risk intensity.

Monthly Status:

Beginning with the sixth month after implementation, a Monthly report of the status of progress Shall be received by noon of the tenth business day of the following month. This report must be tied to the performance section of the Contractor's work plan of operations. The reports Shall provide sufficient information to allow the Department to assess the progress of the CCM program and the Contractor. The contents Shall be same as the Weekly Status Report.

An additional Monthly report is required that is separate from the summary of Care Management for each month. This report is a file of current CCM Enrollees. It Shall be submitted to the Department on the first day of each month via FTP. The format Shall be approved by the Department. The Report requirements include:

a. The Medicaid ID of each CCM Enrollee;

b. The initial Enrollment date for each Enrollee

c. The level of intensity of each Participant;

d. Any Referrals made, the reason why, and the outcome of the Referral;

e. The full name of each Enrollee;

f. The Enrollees' date of birth; and

g. Enrollees' primary and secondary conditions.

4.18.2 Outreach and Participation Reports

The Contractor Shall provide a Quarterly Outreach and Participation Report that describes the CCM related outreach activities completed in the preceding three months, the average Monthly case load of care managers, and the results of those activities. At a minimum, the results Shall include:

a. Staff levels, vacant positions, and any other changes in key staff;

b. The number of CCM-Eligibles identified, the method of contact, and their geographic location;

c. The number of CCM-Eligibles that the Contractor was unable to contact, and why;

d. The number of contacts attempted;

e. The number of CCM-Eligibles reached. Of those reached, the number of those who chose to participate and were enrolled;

f. The number of CCM-Eligibles who opted out of the program and why;

g. The number of Participants who were enrolled in the program and their demographic information (race, age, and gender), including the number in each of the tiers;

h. The length of time Participants have been enrolled, including the length of time in each Tier;

i. The number of Participants who were disenrolled from the program, and an explanation as to why the Participants were disenrolled; and

j. Discussion of lessons learned from outreach activities and how future activities Shall be modified to incorporate lessons learned.

4.18.3 Call Center Activity Reports

Call Center reporting Shall be provided bi-Monthly for the first three months after program implementation and Monthly thereafter, and at a minimum, Shall include the following:

a. Total hours of daily Call Center access provided, hours of downtime, and an explanation of why downtime occurred;

b. The number of outbound calls attempted and completed;

c. Overall call volume, including the number of calls made to the Call Center and calls answered. Include separated by type of call, including nature of Inquiry and source of call (Must provide a separate report for Provider and Participant calls);

d. Abandonment rate;

e. Average time to answer incoming call;

f. Comprehensive report on the nature of calls received, with counts of the twenty most frequent types of calls handled during the month;

g. Detailed statistics regarding Participant and Provider Grievances;

h. Average time required to call back when a call back was required and the percent of all call backs that took more than 24 hours;

i. Average length of calls handled; and

j. Outcomes of Call Center quality improvement measurements.

The Contractor Shall report individual call activity data to the Department upon request.

4.18.4 QM/QI Meeting Reports

The Contractor Shall submit the minutes of its QM/QI meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact Shall be reported.

4.18.5 Satisfaction Surveys

The Contractor Shall Contract with a third party to conduct, at a minimum, an Annual Participant Satisfaction and a Provider Satisfaction Survey. The survey questions and methodology Shall be approved by the Department prior to conducting the survey. The Contractor Shall submit a schedule with the proposal that outlines the timeframe the satisfaction surveys Shall be administered. All costs incurred are the responsibility of the Contractor.

4.18.6 Public Filings

The Contractor Shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this RFP.

4.18.7 Grievance Reports

The Contractor Shall provide a Monthly report to the Department of the number of Grievances by type and the type of assistance provided as described in this RFP.

4.18.8 Annual Report

The annual report Shall include, but not be limited to, the following activities: Enrollee and Provider Outreach, Call Center, Grievances and Appeals, Enrollee Participation, Care Management, clinical outcomes, and Health Care Expenditure Savings.

Prior to the submission of the Contractor's final findings and annual report, the Contractor Shall provide an annual presentation in person of its findings to the Department for discussion.

The Offeror Shall submit a sample of an annual report with its response to the RFP. The Department Shall approve the final reporting format and contents. The Contractor Shall modify the final report to the agreed upon specifications at no cost to the Department.

4.18.9 General Assembly Report

The Contractor Shall submit a progress report no later than the fifteenth day of August of each calendar year. This report Shall give an overview of the CCM program including a narrative explanation of the Contractor operations and responsibilities, the number of Enrollees, progress in meeting CCM goals, clinical outcomes, utilization of services, savings, and HEDIS measurement data. The

Contractor should review the Virginia Medicaid Healthy Returns Disease Management Program Report to the Governor and the General Assembly of Virginia. This report can be located on the Department's website at: http://www.dmas.virginia.gov/downloads/pdfs/DM_Rpt_to_GeneralAssembly.pdf.

4.18.10 Clinical Outcomes Report

The Contractor Shall submit an annual report that Shall include a summary of the clinical outcomes provided as described in this Section. At a minimum, the outcomes, when compared to the health status baseline, reflect:

- The improved overall health status of Participants;
- The decrease in inpatient hospital admissions;
- The decrease in total inpatient hospital days;
- The decrease in non-emergent emergency room visits;
- The increased coordination and reduction of unnecessary or inappropriate medications; and
- The increase in Participant self-management skills.

4.18.11 Utilization and Health Care Monthly Expenditures Report

The Contractor Shall submit after the first year of operation and Annually thereafter a report that Shall include a summary of the net savings as defined through the approved Predictive Modeling methodology. The report Shall also include a breakdown of changes to cost and utilization for at least the following services by disease state:

- Inpatient hospital admissions and readmissions for enrolled Participants;
- Emergency room visits, ambulatory care visits, and inpatient days per admission for enrolled Participants;
- Prescription drugs; and
- Utilization/physician office visits.

4.18.12 Fraud and Abuse Report

The Contractor Shall promptly furnish the Department with a report of suspected Fraud and abuse of Medicaid funds and services within two (2) Business Daysof initiation of any investigative action by the Contractor. The Contractor Shall also furnish the Department with a report of suspected Fraud and abuse on Medicaid Participants within two (2) Business Days of initiation of any investigative action by the Contractor. If the Contractor suspects Fraud, abuse or neglect upon a Medicaid Participant, the appropriate authorities Shall be contacted. Additional information on reporting and handling Fraud and abuse is located in Section 5.2 of this RFP.

4.18.13 Audited Financial Statements and Income Statements

The Contractor Shall provide to the Department copies of its annual audited financial (or fiscal) statements no later than ninety (90) calendar days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) calendar days after the end of each calendar quarter.

4.18.14 Other Reporting Requirements

The Contractor Shall also provide up to three additional Monthly and ad hoc reports in relation to the RFP (and resulting Contract) requirements in a format as agreed upon by the Department and the Contractor. The Department Shall incur no expense in the generation of such reports. Additionally, the Contractor Shall make revisions in the data elements or format of the reports required in this RFP and resulting Contract upon request of the Department and without additional charge to the Department. The Department Shall provide written notice of such requested revisions or format changes in a notice of required report revisions. The Contractor Shall maintain a data gathering and storage system sufficient to meet the requirements of this RFP.

4.19 Readiness for Implementation

No later than one month prior to the program's implementation start date the Contractor Shall demonstrate to the Department's satisfaction its readiness to perform all duties in the relevant scope of work. The demonstration Shall show that the Contractor has met all requirements, including but not limited to:

- Hiring and training of staff;
- Written materials;
- Telecommunications systems;
- CCMIPS and VaMMIS connectivity and other system requirements; and
- QA/QI requirements.

The Contractor's demonstration is in the form of reports and actual demonstration of systems and/or processes with the Department. If the Contractor in unable to demonstrate to the Department's satisfaction that it is fully capable of performing all duties specified in this RFP on the implementation date, there Shall be grounds for the immediate termination of the Contract by the Department pursuant to the Department Special Terms and Conditions, 11.7 Terminations.

4.20 Implementation Time Table

Administration of the CCM Program by the Contractor Shall begin on Monday, January 5, 2009. ("Implementation"). Payment to the Contractor as provided in Section 7.2 (Monthly Invoicing) of this Contract Shall begin upon implementation. The Contractor Shall not be compensated for any expenses incurred prior to the implementation date.

The Offeror Shall include with its response to the RFP proposal a detailed implementation strategy that it Shall utilize to achieve the projected participation utilization to implement the CCM program 90-days from the award of the Contract for this RFP.

The Offeror's proposed strategy Shall sufficiently describe the basis for the Offeror's administrative per member per month (PMPM) cost proposal. The Contractor Shall submit an updated implementation strategy and work plan one week after being awarded the Contract for this RFP. Additional information regarding weekly implementation work plan status reports can be found in Section 4.19.1 of this RFP.

The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the service. The Offeror Shall furnish to the Department all information and data for this purpose as requested. The Department reserves the right to inspect Offeror's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, the Offeror fails to satisfy the Department that the Offeror is properly qualified to carry out the obligations of the Contract and to provide the services specified therein.

The Contractor Shall receive an initial batch of claims processing data prior to the Contract implementation date.

4.21 Transition Upon Termination Requirements

At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor after termination or expiration of the Contract, the Department Shall notify the Contractor of the need for transition. Such notice Shall be provided at least sixty (60) calendar days prior to the date the Contract Shall expire, or at the time the Department provides notice of termination to Contractor. The transition process Shall commence immediately upon such notification and Shall, at no additional cost to the Department, continue past the date of Contract termination or expiration if, due to the actions or inactions of the Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor Shall negotiate in good faith a Contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor Shall continue to perform operations on a month-to-month basis for up to six (6) months beyond the planned transfer date. The Department Shall withhold final payment to the Contractor until transition to the new Contractor is complete.

4.21.1 Close Out and Transition Procedures

Within ten (10) Business Daysafter receipt of written notifications by the Department of the initiation of the transition, Contractor Shall provide to the Department a detailed electronic document, containing the following:

a. The number of individuals enrolled in the CCM program;

b. Each Participant's name and identification number; and

c. Information on any pending Grievances.

4.21.2 Written Instructions

Within ten (10) Business Daysafter receipt of the detailed document, the Department Shall provide the Contractor with written instructions, which Shall include, but not be limited to, the following:

a. The packaging, documentation, delivery location, and delivery date of all records, data and review information to be transferred. The delivery period Shall not exceed thirty (30) calendar days from the date the instructions are issued by the Department; and

b. The date, time, and location of any transition meeting to be held among the Department, Contractor, and any incoming Contractor. The Contractor Shall provide a minimum of two (2) individuals to attend the transition meeting and those individuals Shall be proficient in and knowledgeable about the materials to be transferred.

4.21.3 Questions Submitted

Within five (5) Business Daysafter receipt of the materials from Contractor, the Department Shall submit to the Contractor in writing any questions the Department has with regard to the materials transferred by the Contractor. Within five (5) Business Daysafter receipt of the questions, the Contractor Shall provide written answers to the Department.

4.21.4 Copyright and Patent Rights

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this Contract Shall become the sole property of the Department. Upon request, the Contractor Shall promptly provide an acknowledgment or assignment, in a tangible form approved by the Department, which demonstrates the Department's sole ownership of specifically identified intellectual property created or developed in the performance of the Contract.

4.22 Patient Incentive Plan (PIP)

The Department Shall receive as an optional service administrated by the Contractor a Patient Incentive Program, or Patient Incentive Plan (PIP). This is not a mandatory service within the RFP and Contract, but an initiative that the Department is considering

and would like the Offeror to submit a proposal that demonstrates creative approaches to Care Management of CCM Participants.

A patient incentive plan is to be designed to reward CCM Participants for changes in their behaviors, adherence to treatment plans, and improvements on preventive measures. The rewards can be administered in various ways, but the rewards should be health related, including adherence to treatment plans, preventive measures, and health related behavior improvements. The Offeror Shall describe the administrative process, criteria, rewards, and tracking system. If the Offeror submits a PIP, the cost of a PIP should be separated from the PMPM cost proposal.

4.23 Cost Proposal

The Offeror Shall include with its response to the RFP a per-Member per-month (PMPM) cost proposal for a two tier CCM program. The proposal Shall include separate PMPM for proposals for 1% - 787 potential Enrollees, 2.5% - 1,968, and 5% - 3,935, of the total number of potential Eligibles. See Table E below. See Attachment IV for a complete proposal table. The PMPM costs Shall include all necessary expenses, including eligibility determination, Enrollment, administration, and care management.

4.23.1 Cost Proposal

Tier 1 Participants – 5% of actual Enrollees
Tier 2 Participants – 95% of actual Enrollees

The percentages used for Tier 1 and Tier 2 are for this cost proposal only. The actual percentage of Enrollees in Tier 1 and Tier 2 Shall be based on risk scoring in the Predictive Modeling methodology and current Enrollee data.

Table E – Dual CCM Program Cost Proposal

Percent of Potential Eligibles *(see page 19)*	Tier-1	Tier-2
1%	$PMPM	$PMPM
2.5%	$PMPM	$PMPM
5%	$PMPM	$PMPM

4.23.2 Itemization of Costs

The Department is also requesting an additional cost proposal of the following two services. These two proposed costs are for informational purposes only. They will not be used in the cost proposal process evaluation.

The Offeror Shall give an itemized pricing on the following services, as stated in Table F:

- Predictive Modeling – processing of the Department's claims and eligibility data on a Monthly and a Quarterly basis; and

- Locating potential Enrollees – as related to the recruitment and Enrollment process, but would be for service that is above the Contract requirement.

Table F – Itemized Service Cost Proposal

Service	Predictive Modeling Per Quarter	Locating Service
1% of Potential Eligibles	$	$
2.5% of Potential Eligibles	$	$
5% of Potential Eligibles	$	$

SECTION 5 FRAUD AND ABUSE

5.1 Prevention/Detection of Facility Fraud and Abuse

The Contractor Shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected Fraud and abuse activities. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR Parts 455 and 456. The Contractor Shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential Fraud and abuse activities.

5.2 Fraud and Abuse Compliance Plan

a. The Contractor Shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls and polices and procedures Shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department with this RFP and as an annual submission as part of the Contract. The Plan must define how the Contractor Shall adequately identify and report suspected Fraud and abuse by Enrollees, by network facilities, by Sub-Contractors, and by the Contractor. The Plan must be submitted Annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, Fraudulent Marketing practices, or other types of Fraud and program abuse, and describe the type and frequency of training that Shall be provided to detect Fraud. All Fraudulent activities or other program abuses Shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

   The Department Shall provide notice of approval, denial, or modification to the Contractor within thirty (30) calendar days of annual submission. The Contractor Shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within thirty (30) calendar days of a request. At a minimum the written plan Shall:

   i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud and abuse

compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and Fraud in the administration and delivery of services under this Contract;

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and Fraud, such as:

a. Relevant Sub-Contractor and Facility agreement provisions;

b. Written material regarding Fraud and abuse referrals.

iv. Contain provisions for the confidential reporting by facilities and Sub-Contractors of plan violations to the designated person as described in item b. below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

vii. Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating Fraud and abuse compliance plan violations;

viii. Require any confirmed or suspected facility Fraud and abuse under state or federal law be reported to the Department and that Enrollee Fraud and abuse be reported to the Department; and

ix. Ensure that no individual who reports plan violations or suspected Fraud and abuse is retaliated against.

b. The Contractor Shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the Fraud and abuse compliance plan.

c. The Contractor Shall report incidents of potential or actual Fraud and abuse to the Department within two (2) Business Days of initiation of any investigative action by the Contractor or within two (2) Business Days of Contractor notification that another entity is conducting such an investigation of the Contractor. All reports Shall be sent to the Department in writing and Shall include a detailed account of the incident, including names, dates, places, and suspected Fraudulent activities. The Contractor Shall cooperate with all Fraud and abuse investigation efforts by the Department and other State and Federal offices. The Contractor Shall provide an annual report to the Department of all activities and results.

SECTION 6 THE DEPARTMENT'S RESPONSIBILITIES

The Department Shall oversee the CCM program, including overall program management, determination of policy and monitoring of services. The Department Shall

work in partnership with the Contractor to develop a quality program. The primary responsibilities of the Department include:

a) Making final decisions regarding all policy issues;

b) Providing on-going project oversight, management, and evaluation to include announced and unannounced visits to ensure regulatory compliance;

c) Provide the Contractor with access to relevant Medicaid and FAMIS FFS eligibility and health care expenditure claims data for Medicaid and FAMIS FFS Enrollees and the physician Provider file;

d) Conducting field observations of operations and the Call Center;

e) Monitoring staffing levels, outreach to Enrollees, Enrollee utilization, and other monitoring;

f) Reviewing and approving any Contractor written policies, Sub-Contracts and/or procedural communications to Recipients, Providers, and others prior to release;

g) Providing training to local area agencies on aging, social service agencies, and other human service agencies/organization to inform and educate them about the CCM program;

h) Participating in QI/QA activities;

i) Promoting the program by informing Enrollees and contracted Medicaid Providers;

j) Conducting an evaluation to include the barriers and successes of the CCM program based on Participant claims data and measures provided by the Contractor as specified in Section 4 of this RFP; and

k) Performing periodic audits of the Contractor's contractual compliance. Such audits Shall commence upon 30 days written notice by the Department's Division of Internal Audit to the Contractor that the Department Shall be conducting a review of enumerated aspects of the Contractor's contractual compliance. The scope and estimated duration of each review Shall be specified in writing.

SECTION 7 PAYMENTS TO THE CONTRACTOR

Payments to the Contractor Shall be made Monthly at the contracted fixed PMPM fee. The overall annual total of payments to the Contractor for the contracted services Shall be limited to the total amount agreed to by the Department and the Contractor in the Contract negotiations. The Department Shall not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive based on a percentage of any overpayments identified during the audits. Payments to the Contractor Shall also be subject to the General Terms and Conditions and the Special Terms and Conditions of Sections 10 and 11 respectively of this RFP.

The payment of the invoice by the Department Shall not prejudice the Department's right to object to or question any invoice or matter in relation thereto. Such payment by the

Department Shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

7.1 Annual Review of Controls

The Contractor Shall provide to the Department and the State Treasurer a statement from its external auditor that a review of the Company's internal accounting controls reveals no conditions believed to be a material weakness in the proper administration of the Department's CCM Program in accordance with sound business principles. The written statement Shall be provided Annually each June 15 for the preceding calendar year.

7.2 Monthly Invoicing

The Contractor Shall be paid Monthly based on a Monthly invoice submitted by the 10th day of the following month. Medicaid and FAMIS FFS categories make up the PMPM rate category and Shall be reimbursed at the PMPM rate of reimbursement for Participants as determined in the RFP award and subsequent Contract negotiations. The Contractor's payment Shall be based on Enrollment reported by the Contractor of CCM Participants.

The Contractor Shall report the number of Participants enrolled in the program, and if there is a separate PMPM for Tier-1 and Tier-2, the Contractor Shall report the number of Participants in each tier to the Department in an Enrollment report by the 25th day of each month of the Contract period. Payment Shall be made to the Contractor on the subsequent month following confirmation of Enrollment. The Department Shall arrange for payment each month at an agreed upon time by the Department and the Contractor for administrative payments as described herein.

Each Monthly PMPM payment to the Contractor Shall be equal to the number of Enrollees recognized by the Department multiplied by the administrative fee for the appropriate Enrollee-funding category. Payment is based on the number of Participants enrolled into the CCM program, and not the number of Eligibles for the month. The Contractor Shall only receive PMPM payment for Participants that meet the Enrollment requirements and are recognized as enrolled Participants by the Department. Enrollment criteria can be found in Section 4.1.2.

Payments to the Contractor Shall begin upon successful implementation of the program. The Contractor Shall not be compensated for any expenses incurred during the implementation period, which is from the date that the contract is executed to January 5, 2009 (proposed contract start date). The Contractor must include all implementation costs into its PMPM cost fee.

All costs for services provided in the proposal and resulting Contract Shall be included in RFP response by the Offeror. There Shall be no separate compensation for any other costs including, but not limited to, supplies or any other expenses. See ATTACHMENT IV.

7.3 Cost Neutrality

The Department requires at a minimum a cost neutrality for the CCM program by the Contractor. The Offeror Shall include in the response to this RFP how it will achieve the reductions and net savings by the end of each State fiscal year to have a cost neutral program for the Department.

It is the Department's intentions to have a minimum net savings, or return on investment, of a 2:1 ratio for each State Fiscal Year of Contract participation. Cost targets are to be based on claims analysis. Cost proposals that offer a guaranteed net savings of 2:1 or higher Shall receive a disproportionately higher score than those who do not offer a guaranteed net savings. The Offeror should reference Attachment V.

The Department will Contract with a third party to measure and verify the cost neutrality or return on investment of the CCM program.

7.4 Travel Compensation

The Contractor Shall not be compensated or reimbursed for travel, meals, or lodging.

7.5 Invoice Reductions

The Contractor's invoice Shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Department, on the basis of audits conducted in accordance with the terms of the Contract, not to constitute proper remuneration for compensable services. This Shall include any reductions based on projected reductions in overall health care expenditures and projected clinical outcomes of CCM program Participants (proportionate savings) that are not realized by the Contractor each State Fiscal Year.

7.6 Deductions

The Department reserves the right to deduct from amounts which are or Shall become due and payable to the Contractor under this or any Contract between the Contractor and the Commonwealth of Virginia any amounts which are or Shall become due and payable to the Commonwealth of Virginia by the Contractor, including but not limited to any assessed liquidated damages.

SECTION 8 PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror Shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements for each proposal and the specific requirements for the Technical Proposal and the Cost Proposal.

8.1 Overview

Both the Technical Proposal and the Cost Proposal Shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals Shall be prepared simply and economically, and they Shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that the Department may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals Shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

8.2 Critical Elements of the Technical Proposal

The Offeror Shall cross reference its Technical Proposal with each requirement listed in the appropriate section of this RFP. The Offeror Shall assure that the following documentation is included in the proposal:

Corporate Experience and Qualification: This includes accreditation and experience with Disease Management or Chronic Care Management comparable to this proposed target population.

Projected Participation and Utilization Goals: As described in Sections 3 and 4, the Offeror Shall include with its proposal projections for the next three years for Enrollee participation. In addition the Offeror Shall report in detail the implementation strategy and work plan that it Shall utilize to achieve the projected utilization goals, and how satisfaction Shall be measured.

Care Management: The Offeror Shall include with its proposal how Care Management services Shall be provided. The Offeror Shall report in detail the implementation strategy it Shall utilize in Care Management for Tier-1 and Tier -2 Enrollees.

The Offeror Shall include a description of its ability to integrate nursing components, psycho-social issues, and behavioral health in a holistic, patient-centric Chronic Care Management model. This includes the management of multiple disease states and co-morbidities.

Clinical Outcomes: The Offeror Shall report in detail the implementation strategy it Shall utilize to achieve the projected clinical outcomes and how clinical outcomes Shall be measured.

Implementation Work Plan and Schedule: The Offeror Shall provide a detailed implementation project and work plan, including deliverables and timelines, as part of the

proposal. A comprehensive report on the status of each task, subtask, and deliverables in the work plan Shall be provided to the Department by the Contractor every week during the weeks between the award of the Contract for this RFP and the implementation date of the CCM program. This detailed plan is due 30 days after the Contract is awarded to the Contractor. See Section 8.5.6 of this RFP for additional information regarding an implementation plan and schedule.

Documentation Shall include other reporting processes and sample reports as outlined in this RFP.

Plan for Outreach and Increased CCM Program Utilization: Submit a detailed description of the manner in which the Offeror proposes to perform these responsibilities as detailed in Section 4. The plan Shall include a step-by-step description of the procedures by which each requirement Shall be met. This Shall include recruit and Enrollment methodologies and processes of Enrollees.

Education: Submit a description of the Offeror's plan to educate Virginia Medicaid Enrollees who are Eligible for the CCM program, as well as the Providers, and others with an interest in the CCM program. The Offeror should recommend education and notification processes to increase compliance rates. The plan Shall include education activities prior to and after implementation.

Enrollment: Submit sample Assessment tools along with an outline and description of the Assessment process used for the initial comprehensive and holistic complete Assessment, and how these tools are used in the development of the treatment plan.

Call Center: Submit a detailed description of how the Offeror Shall staff and operate a toll-free Call Center. The plan Shall describe the information and assistance that Shall be provided by Call Center representatives. The description Shall include how the Call Center (or other telephone lines, if applicable) responses Shall be monitored to ensure accuracy of information provided to callers.

Staffing: The Contractor Shall submit a proposed organization chart; resumes of proposed management and key staff, and job descriptions and the requirements of management and key staff positions. Due to the dominating mental and behavioral health diagnosis of the potential Eligibles for the program, the Contractor Shall have a licensed psychologist(s) and psychiatrist(s) on staff and available to the Care Manager and call center.

This section Shall also include a description of the Contractor's plan for staff training, including components of training curriculum, and a plan for on-going training.

Transition of Care: Submit a detailed description of how the Offeror Shall minimize disruption to Enrollees and Providers particularly in relation to start-up transition of care issues as described in Section 4.

Predictive Modeling Methodology: Submit evidence that the Predictive Modeling methodology and tool is appropriate and optimized on Medicaid diseases and related care issues

for Medicaid populations and based on future predicted costs and not current costs and able to show validation testing results as well as other outcomes as described in Section 4 of this RFP.

Cost Savings: The difference between the expected per member per month health care expenditures and the actual per member per month health care expenditures less program costs Shall be considered a net savings. Include with the proposal the proposed net savings the Offeror expects to generate through the CCM program.

Small Business Sub-Contracting Plan: The Contractor Shall submit a Small Business Sub-Contracting Plan for this procurement. Attachment XI contains the format for providing this information, and Shall be included in the package with the Offeror's Original of the Technical Proposal.

8.3 Binding of Proposal

The Technical Proposal Shall be clearly labeled "Technical Proposal" on the front cover. The Cost Proposal Shall be clearly labeled "Cost Proposal" on the front cover. The legal name of the organization submitting the proposal Shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals Shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted Shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents Shall separate each major section. The title of each major section Shall appear on the tab sheet.

The Offeror Shall submit an original and five (5) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal Shall be bound separately. This submission Shall be in a sealed envelope or sealed box clearly marked "RFP 2008-01" Technical Proposal". In addition, the original of the Cost Proposal Shall be sealed separately and clearly marked "RFP 2008-01" Cost Proposal" and submitted by the response date and time specified in this RFP. The Cost Proposal forms in Attachment IV Shall be used. The Offeror Shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2000 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2000 or compatible format). In addition, the Offeror Shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal and their Cost Proposal.

8.4 Table of Contents

The proposal Shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 3 and 4. Each section of the Technical Proposal Shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist the Department in determining uniform compliance with specific RFP requirements.

8.5 Technical Proposal

The following describes the required format, content and sequence of presentations for the Technical Proposal:

8.5.1 Chapter One: Executive Summary

The Executive Summary Chapter Shall highlight the Offeror's:

1. Understanding of the project requirements;
2. Qualifications as a Contractor for the project; and
3. Overall Approach to the project and a summary of the contents of the proposal.

8.5.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two Shall present the Offeror's qualifications and experience to serve as the Contractor. Specifically, the Offeror Shall describe its:

1. Organization Status:

   a. Name of Project Director for this Contract;
   b. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the Contract is to be written;
   c. Federal employer ID number;
   d. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, project director, and other executive officers);
   e. Name of the parent organization;
   f. Major business services;
   g. Legal status and whether it is a for-profit or a not-for-profit company;
   h. A list of board Members and their organizational affiliations; and
   i. Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience:

   a. Offeror's overall qualifications to carry out a project of this nature and scope;
   b. The Offeror Shall describe the background and success of the Offeror's organization and experience in performing Disease Management or Chronic Care Management services or other human services, specifically implementing state, local or regional programs;

c. The Offeror's knowledge of the Medicaid and/or FAMIS Recipient populations and the communities;

d. For each experience with operating, managing, or contracting for the provision of Disease Management or Chronic Care Management services or other human services, the Offeror Shall indicate the Contract or project title, dates of performance, scope and complexity of Contract, and customer references (see below);

e. Any other related experience the Offeror feels is relevant Shall be included;

f. The Offeror Shall indicate whether the Offeror has had a contract terminated for any reason within the last five years; and

g. The Offeror also Shall indicate if a claim was made on a payment or performance bond. If so, the Offeror Shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References:

a. Two customers or Participants who Shall substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP;

b. Two customers or Participants who can attest to the Offeror's experience with interface files for data loads; and

c. Contact information for all Disease Management or Chronic Care Management contracts for Medicaid or SCHIP/FAMIS products and any Virginia based non-Medicaid groups the Offeror chooses to include, held by the Offeror at any time since January 1, 1999.

The Offeror Shall complete the Reference Form in Attachment I for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:

The Offeror Shall submit evidence of financial stability. The Offeror should submit one of the following financial reports:

a. For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization; or

b. For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

8.5.3 Chapter Three: Tasks and Technical Approach

The Offeror Shall fully describe how it intends to meet all of the tasks required in Section 3 of the RFP and technical proposal requirements listed in Section 4 of this RFP. The Department does not want a "re-write" of the RFP requirements. Specifically, the Offeror Shall describe in detail its proposed approach for each of the required tasks listed in Section 3 and technical proposal requirements in Section 4 including any staff, systems, procedures, or materials that Shall be used to perform these tasks. This includes how each task Shall be performed, what problems need to be overcome, what functions the staff Shall perform, and what assistance Shall be needed from the Department, if any.

Note: The Department welcomes new and innovative approaches to CCM program services. While fully addressing the Contractor objectives of this RFP, the Offeror may also include alternate approaches for the Department's consideration.

8.5.4 Chapter Four: Staffing

The proposal Shall describe the following:

a. Staffing Plan: The Offeror Shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this Contract and relationships of the staff to each function of the organization. Contact information Shall be provided for all key staff involved in the implementation and ongoing management of the program;

b. Staff Qualifications and Résumés: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two (2) pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they Shall fill; and

c. Office Location: A description of the geographical location of the central business office, the billing office, the Call Center and satellite offices, if applicable, Shall be included. In addition, the hours of operation should be noted for each office as applicable to this Contract.

8.5.6 Chapter Six: Project Implementation Work Plan

The Contractor Shall submit, no later than 30 days after the award of the Contract, a detailed Project Plan demonstrating the Contractor's proposed schedule to implement the CCM program on Monday, January 5, 2009. This plan must include a pre-testing of the Call Center (Section 4.7), the Predictive Modeling tool (Section 4:10), and the Contractor's Information Platform System (Section 4:9). Additional pre-testing may be requested by the Department prior to the implementation date.

The proposal Shall describe the following:

Project Implementation Work Plan and Project Management: The proposal Shall include a work plan (Microsoft Project 2000 or compatible version)/Project Work Plan detailing the sequence of events and the time required to implement this project. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work Shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the project timetable from beginning to end Shall be included in the proposal. Key dates and key events relative to the project Shall be clearly described on the chart including critical path of tasks. The Offeror Shall describe its management approach and how its proposed work plan Shall be executed.

Upon award of a Contract, the Contractor Shall prepare written progress reports according to the table in Section 4:19 of this RFP. The Contractor Shall submit additional progress report more frequently as necessary if requested by the Department. The Contractor Shall present this report to the Director, Division of Program Integrity, or his designee.

8.6 Submission Requirements

All information requested in this RFP Shall be submitted in the Offeror's proposal. A Technical Proposal Shall be submitted and a Cost Proposal Shall be submitted in the Offeror's collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and Shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information Shall be clearly marked in the proposal and reasons the information should be confidential Shall be clearly stated.

The Commonwealth agrees that neither it nor its employees, representatives, or agents Shall knowingly divulge any proprietary information with respect to the operation of the software, the technology embodied therein, or any other trade secret or proprietary information related thereto, except as specifically authorized by the Contractor in writing or as required by the Freedom of Information Act or similar law. It Shall be the

Contractor's responsibility to fully comply with § 2.2-4342F of the *Code of Virginia*. All trade secrets or proprietary information must be identified in writing or other tangible form and conspicuously labeled as "proprietary" either prior to or at the time of submission to the Commonwealth.

The Contractor assures that information and data obtained as to personal facts and circumstances related to patients or Participants Shall be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent. Any information to be disclosed, except to the agency, must be in summary, statistical, or other form which does not identify particular individuals. Contractors and their employees working on this project Shall be required to sign the Confidentiality statement in this solicitation.

Ownership of all data, materials, and documentation originated and prepared for the State pursuant to the RFP Shall belong exclusively to the State and be subject to public inspection in accordance with the *Virginia Freedom of Information Act*. Trade secrets or proprietary information submitted by an Offeror Shall not be subject to public disclosure under the *Virginia Freedom of Information Act*; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret materials submitted must be identified by some distinct method such as highlighting or underlining and Shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of the Department, may result in rejection and return of the proposal.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, small-women-owned businesses and small-minority-owned business Shall be submitted with the original Technical Proposal.

8.7 Transmittal Letter

The transmittal letter Shall be on official Contractor letterhead and signed by the individual authorized to legally bind the Offeror to Contract agreements and the terms and conditions contained in this RFP. The Contractor official who signs the proposal transmittal letter Shall be the same person who signs the cover page of the RFP and Addenda.

At a minimum, the transmittal letter Shall contain the following:

1. A Statement that the Offeror meets the required conditions to be an Eligible candidate for the Contract award including:
   a) The Offeror and any related entities must identify any client relationships, contracts or agreements they have with any State or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program facility or Contractor and the general circumstances of the Contract or agreement. This

information will be reviewed by the Department to ensure there are no potential conflicts of interest;

b) Offeror must be able to present sufficient assurances to the State that the award of the Contract to the Offeror Shall not create a conflict of interest between the Contractor, the Department, and its Sub-Contractors; and

c) The Offeror must be licensed to conduct business in the State of Virginia.

2. A Statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;

3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;

4. Designation of an individual as the authorized representative of the Contractor who will interact with the Department on any matters pertaining to this RFP and the resultant Contract; and

5. A Statement agreeing that the Offeror's proposal Shall be valid for a minimum of 180 days from its submission to the Department.

8.8 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror Shall sign the cover page of this RFP as well as the cover page of the Addenda, if issued, to the RFP and submit this along with its proposal.

8.9 Procurement Contact

The principal point of contact for this procurement in the Department Shall be:

Jeff Beard, Contract Monitor

Program Integrity Section
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail ccm@dmas.virginia.gov

All communications and content-related questions regarding this RFP Shall be in writing and directed to the principal point of contact. An Offeror who communicates with any other employees or Contractors of the Department concerning this RFP after issuance of the RFP may be disqualified from this procurement.

8.10 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, Shall arrive at the Department no later than 2:00 p.m. E.S.T. on Wednesday, August 27, 2008. The Department Shall be the sole determining party in establishing the time of arrival of proposals. Late proposals Shall

not be accepted and Shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:
Attention: Chris Banaszak
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: Chris Banaszak
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

If the Department does not receive at least one responsive proposal as a result of this RFP, the Department reserves the right to select a Contractor that best meets its needs. The Department management Shall select this Contractor. The Department also reserves the right to reject all proposals. The Department reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if the Department determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the Department web site at http://www.dmas.virginia.gov/ and the eVA web site at http://www.eva.virginia.gov

8.11 Oral Presentation and Site Visit

The Department may require one or more oral presentations by an Offeror in response to questions that the Department has about the Offeror's proposal. An oral presentation means that the Offeror is physically present in a Department's designated meeting room. The Department Shall allow a minimum five-business day advance notice to the Offeror prior to the date of the oral presentation. Expenses incurred as part of the oral presentation Shall be the Offeror's responsibility.

The Department will make available three months of claims data of potential Eligibles to those Offerors who attend the pre-proposal conference. Offerors Shall be required to sign a confidentiality release upon receiving the data.

The Department may make one or more on-site visits to see the Offeror's operation of another Contract, both Medicaid and non-Medicaid. The Department Shall be solely responsible for its own expenses for travel, food, and lodging.

8.12 RFP Schedule of Events

The following RFP Schedule of Events represents the State's maximum timeframe that Shall be followed for implementation of the program.

TASK	DATE
State Issues RFP	07/16/2008
Mandatory Pre-proposal Conference	08/05/2008
Deadline for Written Comments	08/05/2008
State Issues Responses to Written Comments	08/12/2008
Deadline for Submitting a Proposal to the Department	08/27/2008
Intent to Award	09/24/2008
Contract Signed and Approved	10/03/2008
Readiness Review Begins (Information Systems, QI Program, Enrollee Services and other program components)	12/08/2008
Contract start Date (94-days from Contract Award – date Contractor begins providing CCM services)	01/05/2009

If it becomes necessary to revise any part of this RFP, or if additional data are necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum Shall be issued to all Offerors by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The RFP and subsequent information Shall be listed on the Department's website (www.dmas.virginia.gov) and the eVA web site at http://www.eva.virginia.gov. Offerors are responsible for checking these sites for any addendums or notices regarding this RFP.

SECTION 9 PROPOSAL EVALUATIONS AND AWARD CRITERIA

The Department will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the DMAS Director.

9.1 Evaluation of Minimum Requirements

The Department will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals Shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions Shall deem the proposal non-responsive and subject to disqualification without further consideration. The Department reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet: This form Shall be completed and properly signed by the authorized representative of the Contractor.

Closing Date: The proposal Shall have been received, as provided in this RFP, before the closing of acceptance of proposals, including the number of copies specified.

Compliance: The proposal Shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Sections 7 and 8 of this RFP.

Mandatory Conditions: All mandatory General and Special Terms and Conditions contained in Sections 10 and 11 of this RFP Shall be accepted.

Small Business Planned Utilization: Summarize the planned utilization of DMBE certified small businesses and small businesses owned by women and minorities under the Contract to be awarded as a result of this solicitation. (Attachment XI)

9.2 Proposal Evaluation Criteria

The specific criteria for evaluating proposals include the elements listed below in TABLE J.

TABLE J – EVALUATING CRITERIA ELEMENTS

Criteria	Proposed Weights
1. Corporate Experience and Qualifications	**25%**
Shall have experience with Disease Management or Chronic Care Management programs comparable to this proposed program as refer.	
Experience working with indigent populations, particularly Medicaid and FAMIS, along with other healthcare populations.	
Experience of partnership/ working relationships with the medical community, advocacy groups, and community resources. Includes description of how collaboration, training, and interaction with these groups will occur.	
Accreditation requirements met.	
Qualifications of personnel staff, including skills, knowledge, and experience with the population that will be served in this program. Including training of staff.	
2. Technical Proposal	**25%**
Agreement to comply with all general and specific requirements and conditions.	
The clarity and completeness of the Offeror's proposal to the requirements of this RFP.	
Demonstrated knowledge and ability to integrate nursing components, psycho-social issues, and behavioral health in a holistic, patient-centric	

Chronic Care Management model. Includes the management of multiple disease states and co-morbidities.	
Evidence to support ability to meet the initial implementation date and other implementation and reporting time frames and a project implementation work plan.	
Reporting process to the Department and to Providers.	
Evidence of ability to work with State's Claims data and other formats and feeds.	
Predictive Modeling methodology that is appropriate for this program, and is based on future predicted costs vs current costs.	
A description of how the projected clinical outcomes will be achieved and how they will be measured.	
Description of Participant Enrollment methodology.	
Demonstrate how Offeror will educate potential Enrollees about CCM.	
Description of the Recruitment methodology.	
Description of methodology of risk scoring and stratifying Participants into Tier-1 and Tier-2.	
Description and information on Assessment process and tools.	
Transition Plan.	
Description of Care Management for Tier-1 and Tier-2 Participants.	
Description, operational process, organizational and flow chart of the call center.	
3. Proposed Savings Methodology	**10%**
The factors used by the Offeror for the per member per month cost proposal as identified in Attachment IV.	
How the Offeror will achieve the reductions and net savings by the end of each State fiscal year to have a cost neutral program for the Department.	
Offeror guarantees 2:1cost savings return on investment.	
4. References	**5%**
5. Small Business Subcontracting Plan (Attachment XI)	**20%**
6. Cost	**15%**
The per member, per month (PMPM) cost proposal as identified in Attachment IV. The cost proposal Shall be evaluated but is not the sole deciding factor for the RFP.	

The lowest cost proposal Shall be scored the maximum number of evaluation points for cost. All other cost proposals Shall be evaluated and assigned points for cost in relation to the lowest cost proposal. Although cost proposals are evaluated and weighted, they are not the sole deciding factor for the RFP.

9.3 Oral Presentations

Oral presentations may be conducted with each Offeror to clarify proposal points. See §8.11.

SECTION 10 GENERAL TERMS AND CONDITIONS

10.1 Vendors Manual

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this Contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.State.va.us/dps under "Manuals."

10.2 Applicable Laws and Courts

This solicitation and any resulting Contract Shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto Shall be brought in the courts of the Commonwealth. The Department and the Contractor are encouraged to resolve any issues in controversy arising from the award of the Contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual*. The Contractor Shall comply with all applicable federal, State and local laws, rules and regulations.

10.3 Anti-Discrimination

By submitting their proposals, Offerors certify to the Commonwealth that they Shall conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization Shall not discriminate against any Recipient of goods, services, or disbursements made pursuant to the Contract on the basis of the Recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and Shall be subject to the same rules as other organizations that Contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds Shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every Contract over $10,000, the provisions in Sections 10.3.1 and 10.3.2. below apply:

10.3.1. During the performance of this Contract, the Contractor agrees as follows:

a) The Contractor Shall not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by State law relating to discrimination in employment, except where there is a bona fide

occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, Shall state that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation Shall be deemed sufficient for the purpose of meeting these requirements.

10.3.2. The Contractor Shall include the provisions of 10.3.1 above in every Sub-Contract or purchase order over $10,000, so that the provisions will be binding upon each Sub-Contractor or vendor.

10.4 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or Fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or Sub-Contractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

10.5 Immigration Reform and Control Act Of 1986

By entering into a written contract with the Commonwealth of Virginia, the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

10.6 Debarment Status

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, State or local government from submitting bids or proposals on any type of Contract, nor are they an agent of any person or entity that is currently so debarred.

10.7 Antitrust

By entering into a Contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the

Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said Contract.

10.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

10.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Jeff Beard, Contract Monitor, no later than 2:00 pm on Tuesday, August 5, 2008. Any revisions to the solicitation will be made only by addendum issued by the buyer.

10.10 Payment

1. To Prime Contractor:

    a. Invoices Shall be submitted by the Contractor directly to the payment address shown on the purchase order/Contract. All invoices Shall show the State Contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations);

    b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This Shall not affect offers of discounts for payment in less than 30 days, however;

    c. All services provided under this Contract, that are to be paid for with public funds, Shall be billed by the Contractor at the Contract price, regardless of which public Department is being billed;

    d. The following Shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act; and

    e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the

Commonwealth Shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve the Department of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia*, § 2.2-4363).

2. To Sub-Contractors:

   a. A Contractor awarded a Contract under this solicitation is hereby obligated:

      (1) To pay the Sub-Contractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the Sub-Contractor(s) under the Contract; or

      (2) To notify the Department and the Sub-Contractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

         a. The Contractor is obligated to pay the Sub-Contractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the Contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as Stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary Contract. A Contractor's obligation to pay an interest charge to a Sub-Contractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a small business contracting plan is a condition to the award, Shall deliver to the contracting Department or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from Sub-Contractor default) with the small business contracting plan. Final payment under the Contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the Department or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

10.11 Precedence of Terms

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT Shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions Shall apply.

10.12 Qualifications of Offerors

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror Shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

10.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

10.14 Assignment of Contract

A Contract Shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

10.15 Changes to the Contract

Changes can be made to the Contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the Contract. An increase or decrease in the price of the Contract resulting from such modification Shall be agreed to by the parties as a part of their written agreement to modify the scope of the Contract.

2. The Department may order changes within the general scope of the Contract at any time by written notice to the Contractor. Changes within the scope of the Contract include, but are not limited to, things such as services to be performed or are mandated by changes in Federal or State laws or regulations. The Contractor

Shall comply with the notice upon receipt. The Contractor Shall be compensated for any additional costs incurred as the result of such order and Shall give the Department a credit for any savings. Said compensation Shall be determined by one of the following methods:

a) By mutual agreement between the parties in writing; or

b) By agreeing upon a unit price or using a unit price set forth in the Contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or

c) By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the Contract. The same markup Shall be used for determining a decrease in price as the result of savings realized. The Contractor Shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department Shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the Contract price or time for performance Shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this Contract or, if there is none, in accordance with the dispute provisions of the Commonwealth of Virginia Vendors Manual. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this Contract Shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the Contract generally.

10.16 Default

In case of failure to deliver goods or services in accordance with the Contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy Shall be in addition to any other remedies, which the Commonwealth may have.

10.17 Insurance

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the Contract, it Shall have the following insurance coverage at the time the Contract is awarded. For construction contracts, if any Sub-Contractors are involved, the Sub-Contractor Shall have workers' compensation insurance in accordance with §§

2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any Sub-Contractors will maintain such insurance coverage during the entire term of the Contract and that all insurance coverage Shall be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the Contract Shall be in noncompliance with the Contract.
2. Employer's Liability: $100,000.
3. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in the Contract.)
5. Professional Liability/Errors and Omission $1,000,000 per occurrence, $3,000,000 aggregate.

10.18 Announcement of Award

Upon the award or the announcement of the decision to award a Contract over $50,000, as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA web site (www.eva.virginia.gov) for a minimum of 10 days.

10.19 Drug-Free Workplace

During the performance of this Contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a Statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and

4. Include the provisions of the foregoing clauses in every Sub-Contract or purchase order of over $10,000, so that the provisions will be binding upon each Sub-Contractor or Contractor.

For the purposes of this section, "*drug-free workplace"* means a site for the performance of work done in connection with a specific Contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the Contract.

10.20 Nondiscrimination of Contractors

A Bidder, Offeror, or Contractor Shall not be discriminated against in the solicitation or award of this Contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by State law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the State Department, or institution has made a written determination that employing ex-offenders on the specific Contract is not in its best interest. If the award of this Contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this Contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body Shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative facility.

10.21 eVA Business-To-Government Vendor Registration

The eVA Internet electronic procurement solution, web site portal http://www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth Shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

a. eVA Basic Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.

b. eVA Premium Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

c. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

d. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.

10.22 Availability of Funds

It is understood and agreed between the parties herein that the agency Shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

This program and the fulfillment of this RFP are contingent upon Government funding.

SECTION 11 SPECIAL TERMS AND CONDITIONS

11.1 Access to Premises

The Contractor Shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and Sub-Contractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and Sub-Contractor's contractual activities and Shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and Sub-Contractor Shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits Shall be conducted in a manner as will not unduly interfere with the performance of Contractor or Sub-Contractor's activities. The Contractor Shall be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department Shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives Shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

11.2 Access To and Retention of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its Sub-Contractors with the security and confidentiality of records standards.

11.2.1 Access to Records

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives Shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its Sub-Contractors.

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives, Shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its Sub-Contractors.

11.2.2 Retention of Records

The Contractor Shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the final payment. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the end of said period, however, records Shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

11.3 Advertising

In the event a Contract is awarded for services resulting from this proposal, no indication of such sales or services to the Department will be used in product literature or advertising without prior written permission from the Department. The Contractor Shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any Department or institution of the Commonwealth has purchased or uses its products or services without prior written permission from the Department. The Department must approve any advertising, Marketing or press release connected with this Contract.

11.4 Audit

The Contractor Shall retain all books, records, and other documents relative to this Contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The Department, its authorized agents, and/or State auditors Shall have full access to and the right to examine any of said materials during said period.

11.5 Award

Selection may be made of Offerors who are deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the

Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations Shall be conducted with the Offeror(s) selected. Price Shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency Shall select the Offeror which, in its opinion, has made the best proposal, and Shall award the Contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia*, § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a Contract may be negotiated and awarded to that Offeror. The award document will be a Contract incorporating by reference all the requirements, terms and conditions of the solicitation and the Contractor's proposal as negotiated.

11.6 Best and Final Offer

At the conclusion of negotiations, the Offeror(s) may be asked to submit in writing, a Best and Final Offer (BAFO). After the BAFO is submitted, no further negotiations Shall be conducted with the Offeror(s). The Offeror's proposal will be rescored to combine and include the information contained in the BAFO. The decision to award will be based on the final evaluation including the BAFO.

11.7 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice Shall specify the effective date of the termination;

b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;

c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or

d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

The Contractor Shall not terminate this Contract in part.

Each of these conditions for Contract termination is described in the following paragraphs.

11.7.1 Termination for Convenience

The Contractor may terminate this Contract with or without cause, upon (90) days prior written notice to the Department. In addition, the Contractor may terminate

the Contract by opting out of the renewal clause. Any Contract cancellation notice Shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

11.7.2 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting Contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any Contract cancellation notice Shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

11.7.3 Termination for Unavailable Funds

The Contractor understands and agrees that the Department Shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department Shall cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor Shall be unable or unwilling to provide covered services at reduced rates, the Contract Shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriate or are otherwise inadequate or unavailable to support the continuance of this Contract Shall be final and conclusive.

11.7.4 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under

this provision, the Contractor Shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor Shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network Provider or Sub-Contractor, the Contractor Shall immediately so advise the Department. The Contractor Shall ensure that all tasks that have been delegated to its Sub-Contractor(s) are performed in accordance with the terms of this Contract.

11.7.5 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination Shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor Shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to Enrollee notification, network Provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that the Department determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid or FAMIS Enrollees, the Department may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its Sub-Contractors, the notice of termination Shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties Shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services

similar to those terminated, and the Contractor Shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor Shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert Shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein Shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor Shall be paid for any outstanding payments due less any assessed damages.

11.8 Remedies for Violation, Breach, or Non-Performance of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

11.8.1 Procedure for Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

11.8.2 Remedies Available to the Department

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

11.9 Payment

The Contractor Shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by the Department. The Department will provide adequate prior notice of at least 30 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, the Department Shall make payments as described in Section 7.

Each invoice submitted by the Contractor Shall be subject to the Department approval based on satisfactory performance of contracted services and compliance with all contract

terms. The invoice Shall contain the Federal tax identification number, the contract number and any other information subsequently required by the Department.

11.10 Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From:_____ _____
Name of Offeror Due Date /Time

_____ _____
Street or Box Number City, State, Zip Code

_____
RFP Number

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

11.11 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using Department or to failure of the using Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

11.12 Small Businesses Sub-Contracting and Evidence of Compliance

A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and Sub-Contracts. All potential Offerors are required to submit a Small Business Sub-Contracting Plan (Attachment XI). Unless the Offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the

awarded contract to be Sub-Contracted to other suppliers, the Contractor is encouraged to offer such Sub-Contracting opportunities to DMBE-certified small businesses. This Shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No Offeror or Sub-Contractor Shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of proposals. If small business Sub-Contractors are used, the prime Contractor agrees to report the use of small business Sub-Contractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount Sub-Contracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

B. Each prime Contractor who wins an award in which provision of a small business Sub-Contracting plan is a condition of the award, Shall deliver to the contracting agency or institution on a Quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from Sub-Contractor default) with the small business Sub-Contracting plan. When such business has been Sub-Contracted to these firms and upon completion of the contract, the Contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount Sub-Contracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.

C. Each prime Contractor who wins an award valued over $200,000 Shall deliver to the contracting agency or institution on a Quarterly basis, information on use of Sub-Contractors that are not DMBE-certified small businesses. When such business has been Sub-Contracted to these firms and upon completion of the contract, the Contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount Sub-Contracted, and type of product or service provided.

11.13 Prime Contractor Responsibilities

The Contractor Shall be responsible for completely supervising and directing the work under this contract and all Sub-Contractors that it may utilize, using its best skill and attention. Sub-Contractors who perform work under this contract Shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its Sub-Contractors and of persons employed by it as it is for the acts and omissions of its own employees

11.14 Renewal of Contract

This contract may be renewed by the Commonwealth upon written agreement of both parties for three successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

11.15 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from the Department during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

11.16 HIPAA Compliance

The Contractor Shall comply, and Shall ensure that any and all Sub-Contractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this agreement, and the Contractor Shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor Shall comply with the HIPAA regulations at no additional cost to the Department. The Contractor Shall also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with the Department to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the Department's Internet Site at http://www.dmas.virginia.gov/hpa-home.htm.

11.17 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

11.18 Independent Contractor

Any Contractor awarded a contract under this RFP Shall be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of the Department.

11.19 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract Shall become the sole property of the Commonwealth. On request, the Contractor Shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the

Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

11.20 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed Statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. The Department must be notified within 10 days of any change in ownership. Any change in ownership Shall not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with the Department without the expressed written consent of the DMAS Director.

11.21 eVA Business-To-Government Contracts and Orders:

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

b. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:

(i) DMBE-certified Small Businesses: 1%, Capped at $500 per order; and

(ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at $1,500 per order.

The eVA transaction fee will be assessed approximately 30 days after each purchase order is issued. Any adjustments (increases/decreases) will be handled through eVA change orders.

Internet electronic procurement solution, website portal www.eva.virginia.gov , streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth Shall participate in the eVA Internet e-procurement solution and agree to comply with the following:

If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog Shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eva.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia

11.22 Compliance with Virginia Information Technology Accessibility Standard

The Contractor Shall comply with all State laws and Regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. This accessibility standards are State law see § 2.2-3502 and § 2.2-3503 of The Code of Virginia. Since this is a State law and the regulations apply to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals, the Contractor Shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to The Virginia Code as well as any subsequent revisions to the Virginia Information Technology Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at http://www.vita.virginia.gov/docs/websiteStandards.cfm.

11.23 MANDATORY PREPROPOSAL CONFERENCE

A mandatory preproposal conference will be at 10:00am on Tuesday, August 5, 2008 at the Department of Medical Assistance Services 7th Floor Conference Room, 600 E. Broad Street, Richmond, VA 23219. The purpose of this conference is to allow potential Offerors an opportunity to present questions and obtain clarification relative to any facet of this solicitation.

Due to the importance of all Offerors having a clear understanding of the scope of work and requirements of this solicitation, attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. **Due to space limitations, Offerors will be limited to two representatives each.**

Bring a copy of the solicitation with you. Any changes resulting from this conference will be issued in a written addendum to the solicitation.

11.24 Performance Bonds

The Contractor Shall deliver to the Department purchasing office an executed performance bond, in a form acceptable to the Department, in the amount of two months of the estimated annual contract amount, with the Department as obligee. The surety Shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment Shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by the Department.

ATTACHMENT I

REFERENCES
RFP 2008-01

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of Enrollees Eligible, # of Participants served, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	

ATTACHMENT II

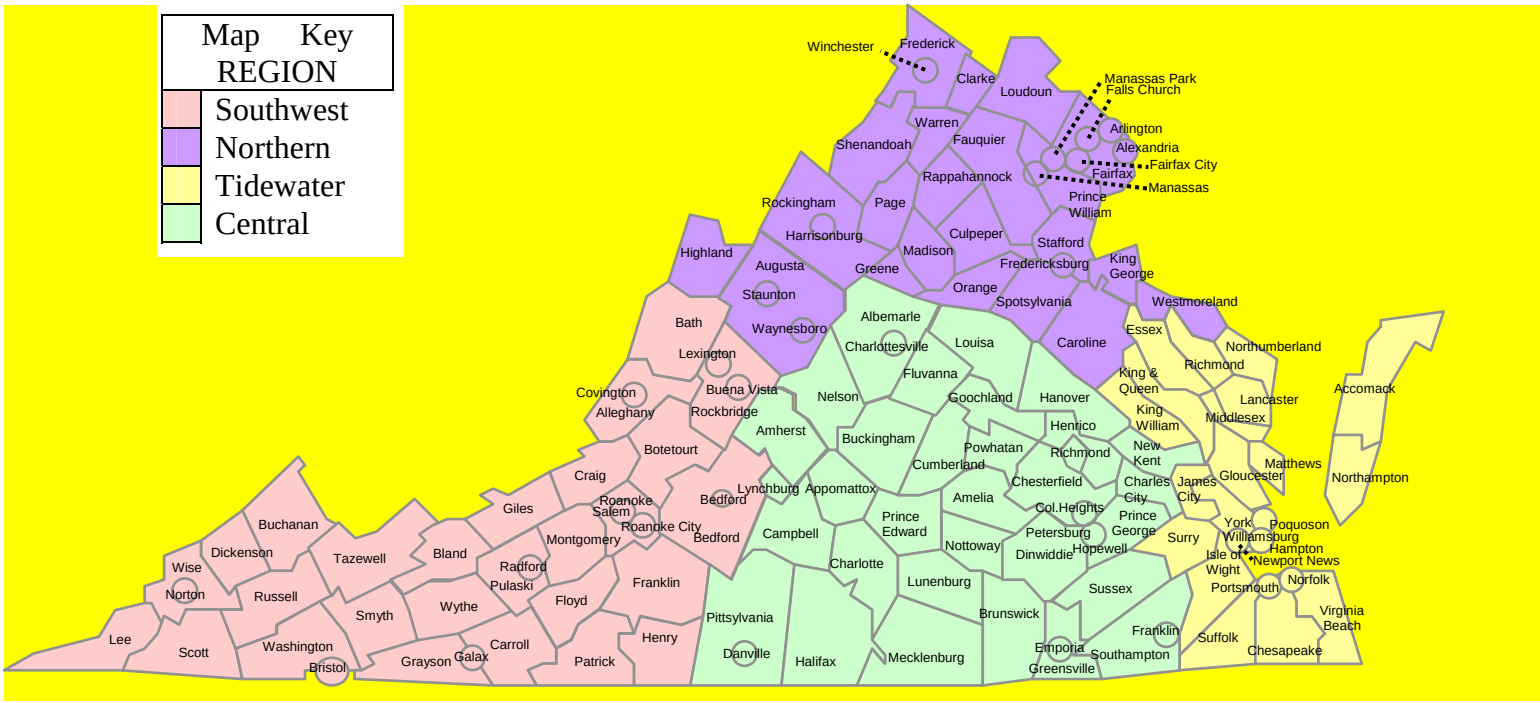
2008-2010 APPROPRIATION ACT LANGUAGE

Item 306.Z.2

The Department Shall report on its efforts to contract for and implement disease state and Chronic Care Management programs in the Medicaid program by November 1 of each year of the biennium, to the Chairmen of the Senate Finance and House Appropriations Committees and the Department of Planning and Budget. The report Shall include estimates of savings that may result from such programs.

ATTACHMENT III

Potential CCM Eligibles Divided by Region



ATTACHMENT IV

COST PROPOSAL: OFFEROR'S COST DETAILS FOR PRICING

(Reference RFP Section 4.23)

COST PROPOSAL – PLAN A – DUAL TIER CCM PROGRAM
Projected Per Member, Per Month Costs

Tier 1 – 5% of Actual Enrollees
Tier 2 – 95% of Actual Enrollees

1% of Total Potential Eligibles

Effective Date	Tier-1	Tier-2
January 1, 2009 – December 31, 2009	$ PMPM	$ PMPM
January 1, 2010 – December 31, 2010	$ PMPM	$ PMPM
January, 2011 – December 31, 2011	$ PMPM	$ PMPM
Total Price for Three Year Contract Period:	$ PMPM	$ PMPM

2.5% of Total Potential Eligibles

Effective Date	Tier-1	Tier-2
January 1, 2009 – December 31, 2009	$ PMPM	$ PMPM
January 1, 2010 – December 31, 2010	$ PMPM	$ PMPM
January, 2011 – December 31, 2011	$ PMPM	$ PMPM
Total Price for Three Year Contract Period:	$ PMPM	$ PMPM

5% of Total Potential Eligibles

Effective Date	Tier-1	Tier-2
January 1, 2009 – December 31, 2009	$ PMPM	$ PMPM
January 1, 2010 – December 31, 2010	$ PMPM	$ PMPM
January, 2011 – December 31, 2011	$ PMPM	$ PMPM
Total Price for Three Year Contract Period:	$ PMPM	$ PMPM

For evaluation purposes, Offerors cost proposals will be evaluated by using the combined total price for the initial three year contract period from each percentage of potential eligibles. Number of potential eligibles is based on fiscal year 2007 as listed in Section 2.

ITEMIZED SERVICE COSTS

1% of Total Potential Eligibles

Effective Date	Predictive Modeling Per Quarter	Locating Service
January 1, 2009 – December 31, 2009	$	$
January 1, 2010 – December 31, 2010	$	$
January, 2011 – December 31, 2011	$	$
Total Price for Three Year Contract Period:	$	$

2.5% of Total Potential Eligibles

Effective Date	Predictive Modeling Per Quarter	Locating Service
January 1, 2009 – December 31, 2009	$	$
January 1, 2010 – December 31, 2010	$	$
January, 2011 – December 31, 2011	$	$
Total Price for Three Year Contract Period:	$	$

5% of Total Potential Eligibles

Effective Date	Predictive Modeling Per Quarter	Locating Service
January 1, 2009 – December 31, 2009	$	$
January 1, 2010 – December 31, 2010	$	$
January, 2011 – December 31, 2011	$	$
Total Price for Three Year Contract Period:	$	$

ATTACHMENT V
(Reference RFP Section 6.2)

Offeror's proposed net savings in the overall health care expenditure costs (including Chronic Care Management fees) in the Eligible population(s).

Proposed Net Savings _____

ATTACHMENT VI

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

Federal legislation and Virginia General Assembly action created a state child health insurance program to cover the kids who did not qualify for Medicaid and who are not covered by private health insurance. The program is called Family Access to Medical Insurance Security (FAMIS). FAMIS is different from past programs in its eligibility and application processes, delivery systems, health care benefits, cost sharing, the opportunity for subsidized employer-sponsored health insurance (FAMIS Select) and outreach activities.

Eligibility and Application

In order to apply for FAMIS, families of children need to complete a FAMIS application and submit it to the FAMIS Central Processing Unit (CPU) or to their local Department of Social Services (DSS), or apply on-line at **www.famis.org**. Families can contact the FAMIS CPU or DSS by telephone to start the process, they can mail or fax their applications directly to the CPU, or they can go to DSS to have their child's eligibility for FAMIS determined. The CPU oversees FAMIS Call Center operations and enrolls Eligible children into the health care delivery system.

2007 FAMIS Income Limits

Size of Family Unit	2006 FAMIS Income Limits 200% of Federal Poverty
1	$20,420
2	$27,380
3	$34,340
4	$41,300
5	$48,260
6	$55,220
7	$62,180
8	$69,140
For each additional person add	$6,960

FAMIS Health Care Delivery Systems

The FAMIS benefit delivery system is available through either managed care organizations (MCOs) or through FAMIS fee-for-service. In most of Virginia, children are enrolled with a contracted managed care entity.

Managed Care Entities

In most areas of the state, Enrollees may choose from at least two managed care organizations (MCOs). The Department offers FAMIS families a choice when receiving their health care, wherever possible. In a few localities, however, there is only one MCO available to FAMIS Enrollees. All children in these areas will be covered by the available MCO and may not request an MCO change. FAMIS Enrollees are not Eligible for the MEDALLION Primary Care Case Management Program.

Once a child is determined to be Eligible, the Enrollee selects an MCO that will provide health care benefits. If they do not select an MCO, one is selected for them. A notice is then sent to the Enrollee confirming the MCO selection. FAMIS Enrollees have 90 days from the effective date of Enrollment with an MCO to change health plans without cause. After 90 days, the Enrollee may not change health plans unless they meet good cause requirements as determined by the Department.

A FAMIS Enrollee living in a managed care area receives a FAMIS evidence of coverage (EOC) and an identification (ID) card from the MCO in which they are enrolled. The EOC and ID card indicate the Enrollee's co-payments for services, important phone numbers and other important program information. The ID card also indicates the Primary Care Provider's name.

The MCOs serving FAMIS children in Virginia include: Anthem HealthKeepers Plus by HealthKeepers, Anthem HealthKeepers Plus by Peninsula Health Care, Anthem HealthKeepers Plus by Priority Health Care, Optima Family Care (formerly Sentara), Southern Health CareNet, Virginia Premier Health Plan, and AMERIGROUP Community Care.

FAMIS children in MCO areas receive the defined comprehensive benefit package based on the state employee benefit plan. FAMIS Enrollees in managed care also may receive other enhanced services from the MCO that are provided at no cost. The MCOs provide additional benefits such as 24-hour nurse advice lines, Disease Management and education for diabetes and asthma. Each MCO also credentials its network Providers to insure that only licensed, well-trained and qualified Providers are treating FAMIS children.

Fee-For-Service

In a few areas of Virginia, where MCOs are not available, the FAMIS benefit delivery system is different. These children receive benefits through FAMIS fee-for-service. They receive a permanent plastic ID card from DMAS, have no co-payments and receive Medicaid-like benefits, including routine transportation service. Some of these children

may be enrolled with a Primary Care Provider and have the doctor's name on their identification card. Please refer to the map below to determine where MCOs are available and where children access FAMIS through fee-for-service.

MANAGED CARE COVERAGE MAP AND MCO CHARACTERISTICS
Figure II-A: Managed Care Coverage Area Map, Effective October 2007

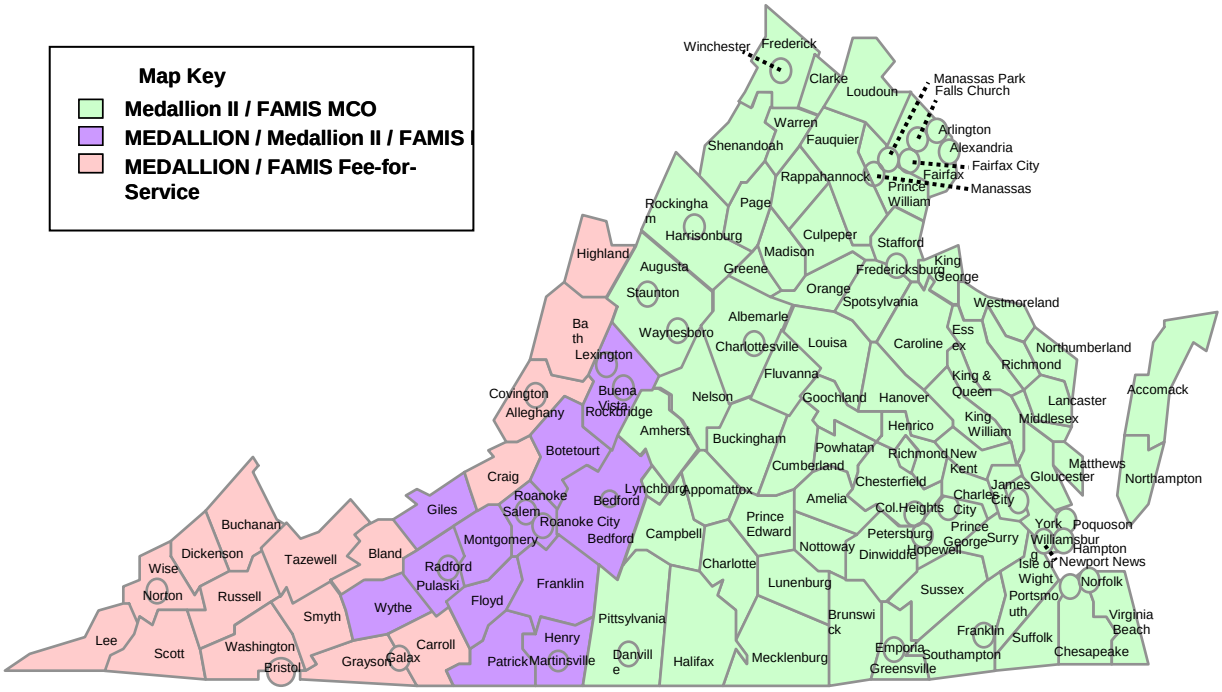


Figure II –B: MCO Characteristics

Health Plans	Enrollees as of October 2007*	Localities and Managed Care Organizations' Start Date
AMERIGROUP Community Care 4425 Corporation Lane Virginia Beach, VA 23462	22,489	11 cities/counties Northern Virginia Start Date: 09/01/2005
Anthem HealthKeepers Plus 2220 Edward Holland Drive Richmond, VA 23230	153,498	81 cities /counties Tidewater, Central Virginia, Halifax , Winchester, Northern Virginia and Charlottesville Regions Start Date: 01/01/1996
Care*N*et / Southern Health Services 9881 Mayland Drive Richmond, VA 23233	19,141	30 cities/counties Tidewater, Central Virginia and Lynchburg Regions Start Date: 04/01/1996
Optima Family Care 4417 Corporation Lane Virginia Beach, Virginia 23462	126,229	76 cities/counties Tidewater, Central Virginia, Charlottesville, Halifax, Winchester and Lynchburg Regions Start Date: 01/01/1996
Virginia Premier Health Plan	117,313	87 cities/counties

600 E. Broad Street, Suite 400 Richmond, VA 23219-1800		Tidewater, Central Virginia, Charlottesville, Roanoke Winchester and Lynchburg Regions Start Date: 01/01/1996

ATTACHMENT VII
Recipient Monitoring Unit

The State of Virginia has a lock-in/mandatory program implemented by the Recipient Monitoring Unit (RMU) within the Department of Medical Assistance Services. The program is called the Client Medical Management Program.

Client Medical Management is a program for clients who have used services in such a way that Medicaid pays more for medical care than is medically necessary. Examples of inappropriate use include:

- Going to the emergency room for problems that can be treated in a practitioner's office or clinic;
- Going to different physicians/practitioners and pharmacies for treatment of the same problem, including receiving the same or similar medications; and
- Using Medicaid transportation services to get non-covered medical services or for personal travel.

The Client Medical Management program is designed to restrict the client to particular Providers for the management of medical care. Clients are assigned to one or more Medicaid Providers (physician and/or pharmacy) for a period of thirty-six (36) months. Clients must follow Client Medical Management procedures to receive treatment from other Providers. This is an "opt-out" program for selected clients.

Each Client Medical Management enrollee has an assigned case manager in the RMU to assist with problems and questions related to the program. The case manager's responsibilities will include, but not limited to:

- Discussing with the clients the reasons for enrollment in Client Medical Management and educating them on the appropriate use of health care;
- Helping the clients understand Client Medical Management procedures and resolve case problems related to Client Medical Management Provider assignments;
- Approve or deny client requests for Provider changes and transfers; and
- Completing a review of client cases prior to the end of their Client Medical Management restriction period to determine if they will be discharged from the program or will need to continue in Client Medical Management.

Who is eligible for RMU Utilization Review: All Medicaid "fee for service" Recipients with the exception of individuals who are:

- Enrolled in an MCO;
- Institutionalized in a long-term care facility; and
- Participating in the Family Planning Waiver.

Identification of Recipients for Review: The "Client Server Surveillance Review System (CS SURS)" is a reporting system that utilizes claims and reference data from the Virginia Medicaid Management and Information System (VaMMIS) to produce utilization information about services rendered by Providers and received by Client Medical Management enrollees.

Referrals are received from many sources, such as doctors, pharmacies, hospitals, social service agencies, family members, law enforcement, other government agencies, and other units within the Department.

Utilization Review Process: A health care analyst within the Department conducts utilization reviews to identify abusive or Fraudulent Medicaid Recipient activity. The reviewing analyst reviews eight (8) to twelve (12) months of current Medicaid claims utilized by the Recipient to research and identify Client Medical Management eligibility criteria. Eligibility criteria can be found in the Virginia Administrative Code, 12 VAC 30-130-800 through 12 VAC 30-130-820. The analyst uses the Enrollee Medical Services Report (paid claims history) and Enrollee Drug Utilization Report from VaMMIS, along with medical records from participating Providers, and the option of contacting Providers to assist in gathering information for the utilization review process.

If the health care analyst does not identify abuse by a client during the utilization review process, the case will be closed. The analyst's research may produce one or more of the following outcomes:

- Contact with the client via educational letters and/or a phone call;
- A Referral to an outside agency, such as a local Department of Social Services Department of Health, and/or Community Services Boards;
- A Referral to another unit with the Department for services;
- A Referral to the Department's Recipient Audit Unit for suspected eligibility Fraud (e.g., card sharing); and/or
- Enrollment in Client Medical Management for up to thirty-six (36) months with restriction on Primary Care Providers and/or designated pharmacies.

Client Medical Management Enrollment Process and Procedures: If a Medicaid Recipient's utilization review determines that he/she meets regulatory criteria for enrollment in Client Medical Management, the Recipient receives written notice from the Department that he/she is enrolled in to Client Medical Management and assigned a primary physician and a designated pharmacy.

The client has an opportunity to choose Providers, or RMU staff will select Providers on their behalf. Medicaid Providers are contacted directly to request participation as a Client Medical Management Provider on behalf of the clients.

Under Client Medical Management, Medicaid pays for covered outpatient medical and/or pharmaceutical services only when they are provided by the designated primary Providers, or by a physician on a Referral form that is from the designated primary health

care Provider, or when the medical services are provided in a medical emergency. Services provided without a Referral from the Primary Care Physician (PCP) or in the absence of an emergency condition are the responsibility of the client, unless the medical service is excluded from the Client Medical Management Referral requirements.

Each Client Medical Management enrolee is assigned to a case manager. The case manager's primary role is to:

- Contact with the client to discuss enrollment and provide education on the appropriate use of health care services;
- Resolve case problems related to Client Medical Management procedures and service Provider assignments;
- Approve and deny requests for service Provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if Client Medical Management restrictions should be extended or end.

ATTACHMENT VIII

Virginia Medicaid *Healthy Returns*[SM] Disease State Management (DSM) Program

Effective January 13, 2006, DMAS rolled out the expanded Virginia Medicaid *Healthy Returns*[SM] Disease State Management (DSM) Program, which is based on the pilot program implemented in 2004. *Healthy Returns*[SM] is a disease state management program designed to help patients better understand and manage asthma (adults and children), diabetes (adults and children), chronic obstructive pulmonary disease (adults and children), coronary artery disease (adults), and congestive heart failure (adults). *Healthy Returns*[SM] is administered by Health Management Corporation (HMC). The program is designed to help patients better understand and manage their health conditions through prevention, education, lifestyle changes, and adherence to prescribed plans of care. *Healthy Returns*[SM] provides DM services through three main interventions: (1) care management; (2) a 24-hour call line; and (3) evidence-based guidelines. *Healthy Returns*[SM] is a voluntary program ("opt-in"). *Healthy Returns*[SM] is offered to all Fee-for-Service Medicaid and FAMIS Enrollees with the exception of: (1) individuals enrolled in Medicaid/FAMIS managed care organizations; (2) individuals enrolled in Medicare (dual eligibles); (3) individuals who live in institutional settings (such as nursing facilities); and, (4) individuals who have third party insurance. *Healthy Returns*[SM] is unique in that it includes individuals who receive home-and-community based waiver services (those who are not dual eligibles).

ATTACHMENT IX

HOME AND COMMUNITY-BASED WAIVER SERVICES PROGRAM DESCRIPTION

Virginia provides a variety of services under home- and community-based waivers to specifically targeted individuals, which include but are not limited to personal care. Each waiver provides specialized services to help individuals in the targeted waiver population to reside in their communities. Individuals in the follow seven waivers are potential eligibles for the CCM program:

- Day Support (DS) Waiver – provides eligible individuals with day supoort and prevocational services in their homes and communities. This waiver provides services to individuals who choose to receive home and community based services as an alternative to care in an alternative to care in an Intermedicate Care Facility for the Mentally Retarded (ICF/MR). According to the Statiscal Record for FY06, 227 unduplicated individuals received DS Waiver services.

- Elderly or Disabled with Consumer Direction (EDCD) Waiver - provides care in the community rather than in a nursing facility for disabled and elderly individuals who meet the level of care criteria and are determined to be at risk of nursing facility placement and for whom community-based care services under the Waiver is the critical service that enables the individual to remain at home rather than being placed in a nursing facility. Individuals must be mentally alert and have no cognitive impairments nor have an appointed guardian if they want to direct their own care, but may have someone else direct their care if they are not able. Approximately 10,161 individuals received services in the Elderly & Disabled Waiver and 417 individuals received services in the CDPAS Waiver during Fiscal Year 2004. These two waivers were combined to create the EDCD Waiver in February 2005. According to the Statiscal Record for FY06, 12,588 unduplicated individuals received EDCD services.

- HIV/AIDS Waiver - provides care in the community rather than in a hospital or nursing facility for individuals who are experiencing medical and functional symptoms associated with HIV/AIDS. According to the Statiscal Record for FY06, 98 unduplicated individuals received HIV/AIDS Waiver services.

- Individual and Family Developmental Disabilities (DD) Support Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of mental retardation who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in an ICF/MR. According to the Statiscal Record for FY06, 388 unduplicated individuals received DD Waiver services.

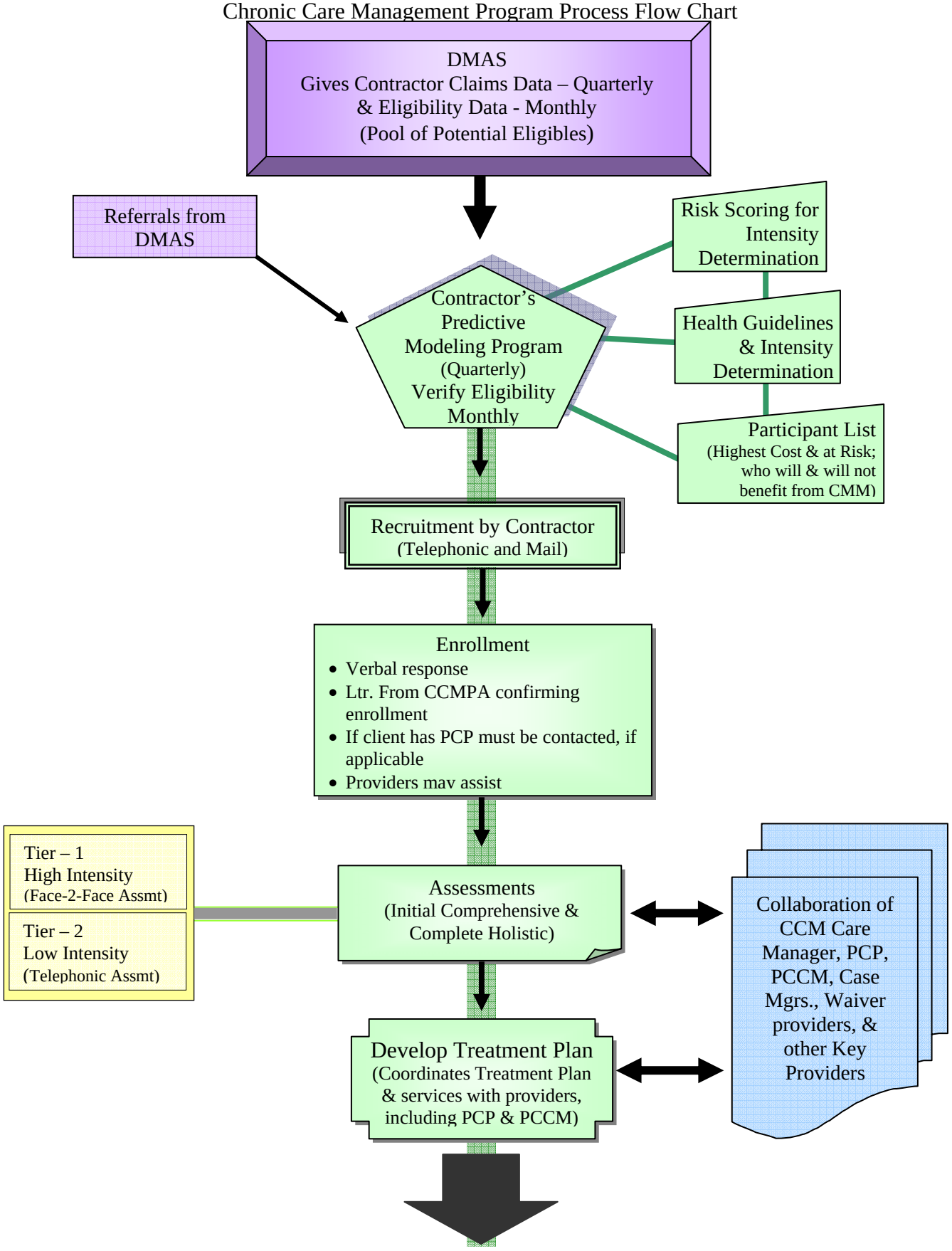
- Mental Retardation (MR) Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation. According to the Statiscal Record for FY06, 6,599 unduplicated individuals received MR Waiver services.

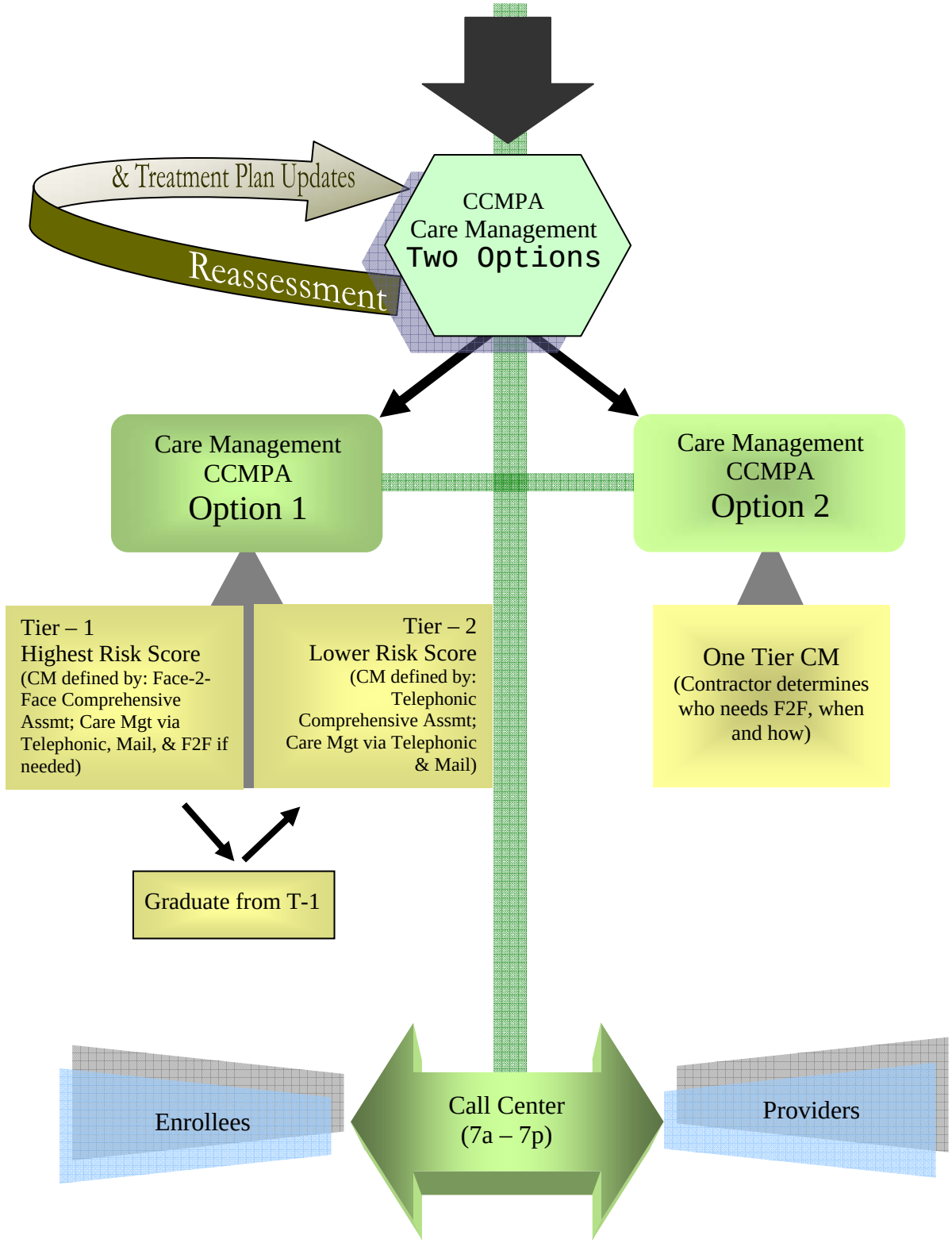
- Technology Assisted (Tech) Waiver - provides care in the community rather than in a nursing facility or hospital for individuals who are dependent upon technological support and require substantial, ongoing nursing care. According to the Statiscal Record for FY06, 295unduplicated individuals received Tech Waiver services.

- Alzheimer's Assisted Living (AAL) Waiver - provides services to eligible residents of assisted living facilities who have a diagnosis of Alzheimer's disease or dementia of the Alzheimer's type. This waiver provides assisted living services to individuals who choose home and community based services as an alternative to nursing facility care. It is for individuals who require 24-hour supervision and are interested in assisted living.

ATTACHMENT X

Chronic Care Management Program Process Flow Chart




& Treatment Plan Updates
Reassessment
CCMPA
Care Management
Two Options
Care Management
CCMPA
Option 1
Care Management
CCMPA
Option 2
Tier – 1
Highest Risk Score
(CM defined by: Face-2-Face Comprehensive Assmt; Care Mgt via Telephonic, Mail, & F2F if needed)
Tier – 2
Lower Risk Score
(CM defined by: Telephonic Comprehensive Assmt; Care Mgt via Telephonic & Mail)
One Tier CM
(Contractor determines who needs F2F, when and how)
Graduate from T-1
Enrollees
Call Center
(7a – 7p)
Providers

ATTACHMENT XI
SMALL BUSINESS SUBCONTRACTING PLAN

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of $10 million or less averaged over the previous three years. Note: This Shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbe.virginia.gov (Customer Service).

Offeror Name: _____

Preparer Name: _____ Date: _____

Instructions

A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This Shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.

B. If you are not a DMBE-certified small business, complete Section B of this form. For the Offeror to receive credit for the small business Subcontracting plan evaluation criteria, the Offeror Shall identify the portions of the contract that will be Subcontracted to DMBE-certified small business in this section. Points will be assigned based on each Offeror's proposed Subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the Offeror's total price.

Section A

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a (**check only one below**):

_____ Small Business

_____ Small and Women-owned Business

_____ Small and Minority-owned Business

Certification number:_____Certification Date:_____

Section B

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This Shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subContractors, suppliers, etc.

B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement

Small Business Name & Address **DMBE Certificate #**	**Status if Small Business is also: Women (W), Minority (M)**	**Contact Person, Telephone & Email**	**Type of Goods and/or Services**	**Planned Involvement During Initial Period of the Contract**	**Planned Contract Dollars During Initial Period of the Contract**
Totals $					